The role and contribution of the Queensland public sector employed nurse educator: A grounded theory study

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ABSTRACT

The purpose of this research was to explore the role of the public sector hospital employed nurse educator in the Australian context. The research context was one of ambiguity surrounding the role of the nurse educator in the development of a culture of learning in nursing (Forster, 2005). National and international literature provides evidence of lack of role clarity and variable role enactment.

An interpretative design was adopted for this research with the theoretical tenets of symbolic interactionism informing data collection and analysis. Using the grounded theory approach of Strauss and Corbin (1998) and as refined by Corbin and Strauss (2008) the main source of data was semi-structured in-depth interviews with a total of fifty-five participants, comprising nurse educators, nurse unit managers and line managers, across eight health service districts in Queensland, Australia. Data analysis was undertaken through the application of the methods of Corbin and Strauss (2008). As data collection and analysis progressed simultaneously, subcategories and categories were modified, accepted or rejected according to their validation or repetition in the existing data (Corbin & Strauss, 2008).

The overriding theoretical understanding of this research, reflected in the concept of *negotiating boundaries,* was generated from conceptual categories and explains how nurse educators negotiated social, political and symbolic boundaries to establish order by which they were accepted as, at once, a resource safety net and a champion of practice standards within health care organisations. Thus *negotiating boundaries* presents a way of interpreting the world that offers an explanation of the complexities and tensions of the public hospital employed nurse educator role and the implications for the role in fulfilling the continuing education needs of the nursing profession.

Thus research produced a theoretical understanding of the public-sector nurse educator's role in the continuing education sector of the nursing profession in Australia. The findings contribute new knowledge and insights into the challenging and contradictory dimensions of the contemporary role of the nurse educator.

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ABBREVATIONS

ANMC	Australian Nursing and Midwifery Council
ANTS	The Australian Nurse Teacher's Society
CPD	Continuing Professional Development
HSD	Health Service Districts
RN	Registered Nurse
ND	Nursing Director
NE	Nurse Educator
NHS	National Health Service
NUM	Nurse Unit Manager
QH	Queensland Health
QHNSDF	Queensland Health Nursing Staff Development Framework
QHNMSDF	Queensland Health Nursing and Midwifery Staff Development Framework
UK	United Kingdom
USA	United States of America
…	Used to indicate certain words, phrases or sentences have been omitted
( )	Used to context of excerpts

STATEMENT OF ORIGINAL AUTHORSHIP

The work contained in this thesis has not been previously submitted to meet the requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no materials previously published or written by another person except where due reference is made.

QUT Verified Signature

Signature

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QUOTE:-

> For too long nursing education has been the 'Cinderella' in all fields of education. Concern for what exits and for improvement should not be the lot of the few, but should be the desire and aim of many. The standard of patient care will depend on the quality of the nursing service and the nursing service will vary in degree according to the ability, quality and knowledge of those providing that service.
>
> (Bartz Schultz 7 July, 1961 as cited in Gregory (1988))

CHAPTER 1 - INTRODUCTION AND BACKGROUND TO THE PROBLEM

1.0 Introduction

Confusion surrounds the role and contribution of the public sector hospital employed nurse educator in the Australian context. This research explores this role and its contribution to the ongoing development needs of the nursing profession. No studies have been found from the past twenty years that directly relate to the role of this group within the profession and the practice of nursing. The purpose of this chapter is to establish a justification for the research, and to give an account of the intention, background, scope and aim of the research.

After consideration of the wide geographical dispersion of nurse educators working in Australia, a pragmatic decision was made to focus the study on the Queensland context and particularly on nurse educators working within one of the three designated area health services that comprised the Queensland Health infrastructure. Overseas research on nurse educator and staff development roles, staff development and continuing professional development, provides theoretical underpinnings and concepts related to nurse educators. However, the impetus for this research arose from workforce redesign needs that have evolved from contemporary health care trends and a rationalisation of health care services (Forster, 2005). A review of the Queensland Health Systems (2005a; hereafter Forster Review) revealed that many clinical staff perceived there were "inadequate training and professional education opportunities with a focus on budgets rather than patient safety and care" (Forster, 2005, p. 251). Additionally, nurse leaders within Queensland Health facilities have expressed a need for the role of the nurse educator to be better understood and utilised more effectively within these facilities.

A prevailing management philosophy based on economic rationalism and sustained pressure on the health care budget has increased scrutiny of any role that is not perceived to provide direct 'bedside' care. Support services provided by hospital employed nurse educators have had this scrutiny (Forster, 2005; Queensland Health, 2010a). In many areas this has resulted in the number of nurse educator positions being reduced, or roles being diluted, by the addition of other considerations such as

project work and administration activities. In some cases, funds have been redirected into clinical services (Davies, 2005; Forster, 2005; Queensland Health, 2010a). Potential dilution and variation in role responsibility have resulted in line managers and nurse educators being less clear about the core elements of the role (Davies, 2005; Queensland Health 2010a). Additionally, users of nurse educator services express dissatisfaction if nurse educators do not perform in the role as expected (Forster, 2005; Queensland Health, 2010a).

Hospital employed nurse educators typically express satisfaction with their work even though their roles may vary (Forster, 2005; Queensland Health, 2010a). However, it is difficult to know how satisfied colleagues within the profession are with the way the nurse educator role supports contemporary practice and builds workforce capacity to sustain service demands (Australian Institute of Health & Welfare, 2008; Forster, 2005; Queensland Health, 2010a). While there is support from both political and industry bodies for nurse educator positions in hospitals, perceptions of the role responsibilities and application vary depending on the environment (Forster, 2005; Queensland Health, 2010a).

In response to the development of a best-practice model (Queensland Health, 2009), Queensland Health commissioned an external consultant to map the role of the nurse educator (Queensland Health, 2010a). The mapping included nursing director, nurse educator and clinical nurse classifications, and focused on interpretation and variation between the classifications (Queensland Health, 2010a). However, the mapping exercise did not research the contribution of the nurse educator or provide further understanding of the role.

1.1 Purpose of Research

The primary purpose of this research was to explore the role and perceived contribution of the Queensland public sector hospital employed nurse educator to the continuing education needs of the nursing profession. This research is thus concerned with both the current role of the hospital employed nurse educator and perceptions of different classifications of nursing staff (clinicians, line managers and nurse educators) on what the nurse educator contributes to the development of the

nursing profession and to Queensland Health (Forster, 2005; Queensland Health, 2010a).

Importantly, even though there is role confusion, Forster (2005) identified the need for enhanced access to and support for continuing professional development across Queensland Health facilities in recommending additional hospital based nurse educator positions. This recommendation was supported by Queensland Health through the funding of an additional sixty nurse educator positions from October 2005. The present research contributes to an understanding of the role in the face of evidence of confusion regarding the role of nurse educator (Christiansen, 2011; Conway & Elwin, 2007; Queensland Health, 2010a; Sayers & DiGiacomo, 2010). Nursing education roles are identified as fundamental in supporting both inexperienced and experienced nurses to apply learning to clinical practice; however there is uncertainty as to who should take the lead role for continuing education (Conway & Elwin, 2007; Gallagher, 2007; McCormack & Slater, 2006; Queensland Health, 2010a). Blurring of role boundaries and responsibilities exists across the different classifications of nurses who contribute to the continuing professional development of nursing staff (Conway & Elwin, 2007; Queensland Health, 2010a). Further, discrepancy in nomenclature, such as 'clinical nurse educator', 'clinical facilitator', 'staff development educator' and 'nurse educator' across Australian states and between countries, contributes to ambiguity in role comparison, clarity and enactment (Christiansen, 2011; Conway & Elwin, 2007; Queensland Health, 2010a). Findings of a recent Queensland Health (2010a) mapping activity indicate ongoing inconsistencies in role expectations, nomenclature, infrastructure and access to services. There is concern that the significance of the nurse educator role may be de-valued or disregarded in a health care system that is saturated with change (Conway & Elwin, 2007; Ferguson, 1996; Queensland Health, 2010a; Scanlan, 2001). An exploration of the confusion pertaining to the nurse educator role and to the contribution the role makes to the ongoing development needs of the nursing profession is an objective of this study.

The research explored perceptions of the role under study, and the interactions surrounding those perceptions in order to generate theoretical understanding that provides insight into the bases for the ambiguity that surrounds the role and contribution of the nurse educator. The research also reinforced the importance of fostering collaborative partnerships, rather than competitive segmental development. Enhanced partnerships will promote the pursuit of professional career goals and foster research in clinically relevant issues. Ideally, partnerships allow for mutual recognition and awareness of each partner's needs, expectations, capabilities, responsibilities and in due course, shared accountability (Happell, 2002; Kanter, 1994).

1.2 Background to Study

Social expectations of high quality health care, acceleration of knowledge and on-going integration of technology require more highly educated nurses which, in turn, places demands on both academic and health care facilities (Griscti & Jacono, 2006; Queensland Health, 2009, 2010a). In contemporary hospitals, continuing education, staff development and inservice activities are viewed as core business in achieving and maintaining nursing staff competence and acceptable patient outcomes. For example, increased accountability and regulation of professions has resulted in 'mandatory and requisite' training and education as a requirement in the clinical domain (Queensland Health, 2010a). Under the national law that governs the operations of the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA), all Australian registered health practitioners must undertake continuing professional development (CPD). The CPD requirements of each National Board are detailed in the Registration Standards for each profession. AHPRA (2010) has determined the requirement for continuing professional development as:

> Continuing professional development (CPD) helps health professionals to maintain, improve and broaden their knowledge, expertise and competence. (AHPRA, 2010, p. 1)

The Nursing and Midwifery Board of Australia Continuing Professional Development Registration Standard (2010) further identifies that all nurses and midwives must meet CPD standards. Here CPD is defined as:

> …the means, by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives. The CPD cycle involves reviewing practice, identifying learning needs, planning and participating in relevant learning activities, and reflecting on the value of those activities. (The Australian Nursing and Midwifery Council (ANMC, 2009, p. 8)

Registered nurses and midwives are required to participate in a minimum 20 hours of nursing CPD relevant to the nurse or midwife's context of practice per year, where one hour of active learning equals one hour of CPD (Nursing and Midwifery Board of Australia, 2010). Responsibility for calculation of hours of active learning undertaken and provision of evidence resides with each nurse or midwife.

Regulatory requirements and rapid changes in health care and technology have made it increasingly difficult for healthcare professionals to maintain the level of knowledge and skills needed to provide quality care. For example, it is projected that the half-life of this form of knowledge is three to five years (McVay Lynch, 2004; Murray & Erdley, 2009; Tobin, 1976 cited in Lombard, 1990). Knowledge can rapidly become obsolete and it is estimated that today's nurses work in health care environments that are twenty times more complex than the typical general or manufacturing business (Bartlets, 2005; Queensland Health, 2010a).

The National Review of Nursing Education (Heath, 2002) identified that, like other professional groups, nurses are expected to engage in continuous upskilling and lifelong learning. Nursing is seen as a practice discipline and therefore clinical education is regarded as an integral and essential component of professional development (Benner, 1984, 1985). The review acknowledged that transition between roles will be a feature of the workplace of the future: as knowledge and technology change, nurses move between roles and leave and re-enter the workforce (Australian Government, 2002). Transition and the necessity for support are integral to normal operations, requiring continued investment in educational infrastructure and 'ready to hand' expertise as a mechanism to assist in bridging the academic-clinical divide (Edmond, 2001).

Nurse educators are deemed a key resource in the preparation of a nursing workforce able to provide quality care to satisfy the health needs of the population (Forster, 2005; National League for Nursing, 2003; Queensland Health, 2010a). Ashton (2012, p. 114) argues that "nurse educators in the staff development setting are uniquely positioned to foster the professional growth of nurses in ways that will give voice to nurses' knowledge and wisdom". Similarly in the mid-1990s, Adrianne (1996) identified nurse educators in staff development roles as unique and central to developments in the health care environment. These perspectives reinforce the latent importance of nurse educators in facilitating learning and development within clinical environments. They influence clinicians and decision making in work units. In the current cost-orientated, rapidly changing health care environment, as exemplified by staff shortages and an increased emphasis on quality of nursing care, hospital employed nurse educators are constantly challenged to achieve the best outcomes for staff and patients (Fleck & Fyfee, 1997; Queensland Health, 2010a).

To gain an appreciation of the impact of the hospital employed nurse educator on clinical practice requires consideration of practical continuing education and the ways in which nurses cultivate a personal capacity for lifelong learning (ANMC, 2009; Gallagher, 2007; Griscti & Jacono, 2006; Queensland Health, 2010b). The importance of continuing and professional development for nurses has progressively been given more emphasis within the profession (ANMC, 2009; Gallagher, 2007; McCormack & Slater, 2006). Notwithstanding, the body of literature reveals a disparity in the ways development is provided, supported and considered in respect of quality nursing care. There is positive acknowledgement in the United Kingdom, American, Canadian and Australian literature that quality nursing care is 'predicated' on quality education (pre-registration, undergraduate and postgraduate) (Christiansen, 2011; Clifford, 1993; Conway & Elwin, 2007; Crotty, 1993; Gallagher, 2007; Heath, 2002; McCormack & Slater, 2006; Queensland Health, 2007b; Victorian Government, 2002).

Many argue that continuing professional development is necessary because of continuing growth in professional knowledge and rapid changes in the health care system with consequent changes in nurses' roles (ANMC, 2009; Brunt, 2003; Glazer, 1999; Lundgren & Houseman, 2002). The perception is that the nurse educator has an integral role in considering how clinical staff are encouraged to take responsibility for their own learning, question practice, and support strategies that embed evidence into practice (Queensland Health, 2010a, 2010b). There are, however, numerous dimensions to the scope of CPD and many individual factors that can influence a nurse's perception of CPD (Ashton, 2012; Barriball, White & Norman, 1992; Gallagher, 2007; Hughes, 2005; Lawton & Wimpenny, 2003). A view is that those in hospital employed nursing education positions need to plan, implement and evaluate CPD programs in partnership with clinicians and managers (Ashton, 2012; Christiansen, 2011; Conway & Elwin, 2007; McCormack & Slater, 2006; Queensland Health, 2010a, 2010b). This means that the public sector employed nurse educator in Queensland is expected to offer programs consistent with professional and service demands (Forster, 2005; Queensland Health, 2010a, 2010b).

Knowledge and skills frameworks have been developed in a number of countries to promote opportunities for continuing professional development in nursing and to assist nurse educators in facilitating nurses' development and application of requisite knowledge, skills and attributes. In the United Kingdom (UK), the National Health System Knowledge and Skills Framework identifies knowledge and skills that individuals need to apply in their position (Department of Health, 2003, hereafter the NHS Framework). The NHS Framework is seen to guide the development of individuals, present a fair and objective platform on which to base review and development for all staff, and provide the basis for pay progression in the service (Department of Health, 2003). It is argued that such a framework assists to identify knowledge gaps, provides timely and equitable relevant continuing professional development, and promotes closer collaboration between the higher education sector and service (Department of Health, 2003; Gould, Berridge & Kelly, 2006; Queensland Health, 2010b). The relationship of the NHS Framework to the nurse educator in the context of this study is not clear in the available literature.

In the United States of America (USA), most states apply a framework of nursing professional development (Hughes, 2005) that includes continuing education, staff development and academic education. The intention of these frameworks is to provide guidance in relation to supporting life-long learning, developing and maintaining competence, enhancing professional practice, and supporting career goals (American Nurses Association (ANA), 2008, 2009; Donely & Flaherty, 2008; Hughes, 2005).

The Queensland Health Nursing and Midwifery Staff Development Framework (QHNMSDF) (2004, 2007a), revised as the *Building Blocks of Lifelong Learning* (2010b, hereafter referred to as the Framework), has some similarities to international frameworks. The Framework identifies mandatory and requisite knowledge and skills and CDP from a life-long learning perspective.

The Framework (Queensland Health, 2010b) aligns to and advances the findings of numerous Australian national and state nursing reviews, namely: the National Review of Nursing Education 'Our Duty of Care' (Australian Government, 2002, hereafter Heath); the Report on the Inquiry into Nursing 'The Patient Profession: Time for Action' (Australian Government, 2003); the 'National Nursing and Nursing Education Taskforce' (Australian Health Ministers Advisory Council, 2006); and the Forster Review (2005). Each review highlighted the importance of clinical education and the need for better access, resources and effective support. Nurse educators (and in particular, neophyte nurse educators) employed by Queensland Health are expected to access and integrate into their practice the overarching principles of the Framework (Queensland Health, 2010b) with respect to their role, practice and professional development initiatives.

The intent of the Framework (Queensland Health, 2010b) is to provide an infrastructure that supports professional practice for nursing while at the same time affording a broad structure and direction for the planning, design and implementation of staff development. In the Framework, staff development is described as:

> …all the educational activities undertaken to improve the occupational and personal knowledge, skills and abilities of employees through a concerted, consistent and continuous process that increases the ability of each person to function both professionally and personally, with the overall aim of improving the quality of care in a health setting. (Dhondea, 2004, p. 30)

The goal of staff development is to "assist the individual worker toward clinical improvement, personal advancement and occupational progress" (Queensland Health, 2004, p. 5). In the Queensland context the term 'staff development' refers generically to orientation programs, transition to practice processes, continuing education and the broad notion of professional development (Queensland Health, 2007a, 2010b). Within the Framework each concept is outlined, providing a clear indication of clinical, organisational and professional expectations as well as the application of evidence into practice, leadership, strategic direction and workforce development priorities (Queensland Health, 2007a, 2010b).

As with the NHS Framework (Department of Health, 2003), staff development processes are managed through a Performance Appraisal and Development System, with views of management and staff integrated in order to define program goals and priorities. The goal is to align individual nurse's performance appraisal and development plans (Gould, Drey & Berridge, 2007; Queensland Health, 2010a). Larcombe and Maggs (1991) advocated this approach in the early 1990s as a strategy for implementing continuing professional development and assessment of needs. Current perspective extends this approach in asserting that an established system of staff appraisal reinforced by a comprehensive program of continuing professional development theoretically reduces adverse patient outcomes and improves team interaction (Gould et al., 2007; Metcalf, 2001; Queensland Health, 2010b).

1.3 Hospital Employed Nurse Educator – Queensland Health

Queensland Health has chosen to pursue a statewide model of staff development for the nursing workforce (registered nurses, enrolled nurses and assistants in nursing). However, there is little clarity around the nurse educator role as a contribution to the model. Currently there are over three hundred and forty

public sector hospital employed nurse educator positions in Queensland (Queensland Health, 2010a). Positions are long-standing and were identified before the 1990 transfer to the higher education sector of nursing training (Adrianne, 1996). At the time of nursing training transfer the nurse educator position was identified as being needed and respected (Adrianne, 1996; Hughes, 2005; Lepine & Ahola-Sidway, 2000; Mateo & Fahje, 1998; Ridge, 2005).

The Ministerial Taskforce Nursing Recruitment and Retention (Queensland Health, 1999) and other internal reviews (Queensland Health, 2005a, 2007b, 2010a) have concluded that, in most Queensland Health facilities, there is confusion regarding the role and responsibilities of the hospital employed nurse educators (in particular the clinical teaching aspect of the role). Although it is difficult to obtain a clear picture of how the nurse educator role is operationalised across organisational settings, this role is responsible for providing clinical and professional development opportunities for nursing staff (Forster, 2005; Lane 1996; Queensland Health, 1999, 2006a, 2010a, 2010b; Sayers, DiGiacomo & Davidson, 2011; Tezak & Chan, 2005).

Before the full transfer of nurse education to the higher education sector in Queensland in the early 1990s, the majority of nurse educators were employed in hospital-based schools of nursing to train nurses to achieve state registration or enrolment to a certificate award level. A small number of nurse educators were also employed to provide staff development and inservice activities, with a primary focus on 'mandatory skills'. Little prominence was placed on upskilling or continuing education, as the prevailing culture supported the belief that little if any ongoing development was necessary for registered and enrolled nurses (Queensland Health, 1999; Stein-Parbury, 2000).

Since the mid-1990s, the predominant role of the nurse educator employed in Queensland Health facilities has been to determine purpose and coordinate training and workforce development which includes design, delivery and evaluation of staff development and continuing professional development programs. These activities are undertaken to assist nurse clinicians to provide contemporary focused nursing care based on best available evidence and in line with professional practice standards (Queensland Health, 2005a, 2010a). However, disparity in how nursing

education initiatives are supported within facilities, variations in how line managers require educators to function, and inconsistencies in position responsibilities throughout the state, make it difficult to determine the contribution to continuing professional needs of the nurse educator role, or indeed if the role is effectively fulfilled by incumbents (Forster, 2005; Queensland Health, 1999, 2010a).

In the nurses' 2006 certified agreement with Queensland Health (2008, pp. 7-8), generic role statements were provided for the positions of Clinical Nurse Consultant, Nurse Unit Manager, Nurse Educator and Nurse Researcher. Generic statements relating to the leadership roles and associated responsibilities emphasised the importance of the nurse educator and espoused the significance of these advanced practice positions. The generic statements identified that these positions were expected to be involved in: leadership and strategic planning activities; coordinating care or specialty services including policy and continuum of care direction and integration; fostering strategies to support a work-based culture that promotes and supports education, learning, research, workplace development planning and quality improvement and locally managing change (Queensland Health, 2008a, pp. 7-8).In addition, the specific statement of purpose, roles and responsibilities of the nurse educator read that:

> The nurse educator is a registered nurse who is accountable at an advanced practice level for the design, implementation and assessment of nursing education programs, managing educational resources and provides nursing expertise relating to educational issues within a nursing service/division/facility/health service district and who: is responsible for integrating the principles of contemporary nurse education into nursing practice.
>
> (Queensland Health, 2008a, pp. 8-9)

In a survey undertaken within one of three Queensland Health area health services in 2006 (8 Health Service Districts comprising 49 hospitals) (Queensland Health, 2006a), substantial variation in the types of models used and lack of consistency in the nature of nurse educator support and role application were identified. This survey (Queensland Health, 2006a) also established that both infrastructure and nurse educator numbers varied considerably. Four different nursing education models were identified: The first is the *corporate* model that comprises all nursing education and staff development services provided through the line-management responsibility of a Nursing Director Education, or Director of

Nursing, or a non-nurse (e.g. Staff Development Manager). Second is the *hybrid* model that is reliant on strategic health service district responsibilities and clinical support being provided by a small core group of nurse educators with line-management responsibility to a Nursing Director, Education, and additional nurse educators employed in services with line-management reporting to a Clinical Nursing Director and professional reporting to the Nursing Director, Education. The third is the *decentralized* model where nurse educators employed within clinical specialties have line-management responsibility only to the Nursing Director of the specialty. Last is the *no definable* model (predominately in rural facilities) where the Director of Nursing allocates an education portfolio to a clinical nurse as an adjunct clinical role.

Another similar survey undertaken statewide in 2010 (Queensland Health, 2010a) produced comparable conclusions to the 2006 survey (Queensland Health, 2006a). Given the number of models and differing infrastructure and line manager support identified in both surveys, it is reasonable to suggest inconsistencies in role application. However, despite variations in models, survey responses and comparison of job descriptions have indicated that there appear to be shared premises regarding the role of the nurse educator. Descriptions emphasise program development, delivery and evaluation; facilitation of learning; demonstration of leadership; fostering evidence based practice and research activities; demonstration of effective teaching skills; and advanced clinical knowledge (Queensland Health, 2006a, 2010a). Differences in how nurse educators functioned in the role were dependent upon facility infrastructure support, model of education, nurse educator experience, educational preparation, and clinical staff demands (Queensland Health, 2006a, 2010a).

Variability exists in Queensland Health facilities regarding clinical imperatives, values, culture, practice standards, access to and extent of staff development activities, and management and leadership styles (Forster, 2005; Queensland Health, 2006a, 2010a). Disparity in line manager perceptions and support for the nurse educator role also occurs (Forster, 2005; Queensland Health, 2006a, 2010a). These findings strongly suggest that the nurse educator role in Queensland Health facilities needs exploration and to be awarded greater clarity

(Queensland Health, 2006a, 2010a). Establishing congruence between expectations and understanding of this role will assist in providing a basis for determining how the role can best contribute to the development of the profession and patient outcomes.

1.4 The Scope of the Study

This study has a focus on the role of the Queensland public sector hospital employed nurse educator in contributing to the continuing education needs of the nursing profession. It investigated the Queensland context and has made a contribution to the nursing profession across Australia.

Queensland Health was chosen for the following reasons:

- access to participants in a wide variety of sites ranging from metropolitan to provincial and rural facilities;
- access to a wide-ranging sample of nurse educators from inexperienced nurse educators to very experienced nurse educators (e.g. in excess of fifteen years in the role); and
- available data, following extensive and comprehensive input from this area health service to both the Queensland Public Hospital Commission of Inquiry (Davies, 2005) and the Forster Review (2005).

1.5 Aims of the Study

The primary aims of the study were to:

- investigate the role and responsibilities of the public sector hospital employed nurse educator in Queensland;
- explore the experiences of public-sector hospital employed nurse educators;
- critically examine the contribution of the public sector hospital employed nurse educator in Queensland to the continuing education needs of the nursing profession;
- develop a theoretical understanding of the role of the public sector hospital employed nurse educator in Queensland and its contribution to the continuing education needs of the profession.

1.6 Clarification of Terms

For clarity, the following definitions sourced from Queensland Health resources are provided (Queensland Health, 2007c, 2010b).

Table 1.1: Definitions

Term	Definition
Organisational Learning	The knowledge and skills required by nurses/midwives to function effectively in their roles to achieve specific organisational aims (Queensland Health, 2010b p. 7).
Clinical Learning	The knowledge and skills specified by the organisation as being essential prerequisites of the workplace to demonstrate acceptable standards of practice in the delivery of patient care (Queensland Health, 2010b p. 7).
Professional Learning	Learning the nurse/midwife engages in relative to broader nursing and midwifery professional issues and trends (Queensland Health, 2010b p. 8).
Transition Process	The support and opportunity provided to assist individuals attain and further develop personal and professional nursing and midwifery knowledge, skills and values to effectively and smoothly transfer in to the health care team (Queensland Health, 2010b p. 11).
Career Development	Is a pathway for continuous development that ensures maintenance of standards and professional growth incorporating a balance of initiating, developing, maintaining and advancing competence in clinical, professional and personal skills and knowledge (Queensland Health, 2010b p. 13).
Continuing Professional Development	All nurses/midwives engaged in any form of nursing/midwifery/ practice will be required to complete CPD that is relevant to the context of their practice. Ongoing support to foster the development of advanced clinical, leadership, management, education and research knowledge and skills is provided to each nurse/midwife in line with requisite role responsibilities and individual development plans (Queensland Health, 2010b p. 18).

Table 1.2 defines and overviews the generic purpose of the roles, from the Queensland Health perspective, of each classification of registered nurse participating in the study.

Table 1.2: Nursing nomenclature in context

Nurse Educator	A registered nurse who manages the development, planning, implementation and evaluation of educational activities designed to advance nursing workforce capacity to provide safe and competent care. The role focus is continuing education, staff development, inservice educational activities and nursing professional development for Registered (RNs Grade 5-12), Enrolled (EN, EN, (Med) and Advanced EN) and Assistant Nurses employed in Queensland Health facilities.
Nurse Unit Manager	A registered nurse who provides nursing leadership in proactively managing and coordinating clinical practice and the provision of human, financial and material resources in a Work Unit in accordance with organisational goals, ensuring a cost effective nursing service focused on patient care.
Nursing Director, Education	A registered nurse who practices at an advanced level to manage the development, planning, implementation, evaluation and support of strategies designed to advance nursing education, and clinical practice standards within a Health Service District. The position provides strategic direction for nursing education and research across the district. The position also facilitates collaborative links with the university sector, area nursing education and research units and state - wide nursing programs to advance nursing education.
Nursing Director	A registered nurse who demonstrates clinical and management expertise and is responsible for the overall planning, coordination, formulation and direction of policies relating to the provision of clinical care, development of partnership models and strategies to support under graduate and post graduate education and research in the workplace and the provision of human and material resources for a clinical division, an assigned number of clinical units, District wide and/or Area Health Service.
Director of Nursing	A registered nurse who demonstrates expertise in clinical practice and management. The Director of Nursing is responsible for the activities of the nursing service in a facility and contributes to the development of facility policy.

(Queensland Health, 2007c)

1.7 Organisation of the Thesis

This thesis comprises seven chapters and numerous appendices. Chapter One provided an introduction to the study and established how the research relates to issues raised by both the profession and in the literature. It included the research background scope, aim, significance of the research and definition of terms.

Chapter Two highlights the location of this study within the literature. As such, a critical analysis of international and national research and scholarship relating to nurse educator roles, staff development and continuing professional development is presented.

Chapter Three explains and justifies the research design adopted in pursuit of the research purpose. The chapter commences with an overview of the research design and justification of the theoretical underpinnings of the study. The concurrent process that characterises the grounded theory methodology of sampling, data generation and analysis is considered separately for ease of description. In addition rigour factors are examined and relevant ethical issues addressed.

Chapter Four focuses on the category *reflecting on attributes and expectation*s which accounts for participant perceptions of the role attributes of nurse educators and how the boundaries they encounter add to the complexity of the role, and influence both actions and the outcomes achieved by nurse educators.

Chapter Five explores the category *constructing workplace learning* which provides an explanation of how the hospital nurse educator constructs and supports workplace learning in the context of the research study. The emphasis of this chapter is on how the nurse educator, as the key facilitator of a learning culture within the workplace, establishes identity through strategies such as engagement with the learner, variation in their involvement and visibility in response to expectations and related workplace issues.

Chapter Six explains how the theoretical understanding *negotiating boundaries* presents a way of looking at the world that offers an explanation of the role of the public hospital employed nurse educator and the implications for the role in fulfilling the continuing education needs of the profession. The theoretical understanding encompassed in *negotiating boundaries* was generated from conceptual categories and not found in the published literature in the form of how it is explained in respect of the study focus. *Negotiating boundaries* reflects how nurse educators negotiate social and symbolic boundaries to establish order by which they are accepted and generally desired as a resource safety net and champion of practice standards within health care organisations.

Chapter Seven concludes in revisiting the study aims and consideration of the implications and limitations of and methodological tensions in the study. Consideration of future research and recommendations arising from the study findings as they relate to the role and contribution of the hospital employed nurse educator, nursing practice and policy are addressed.

CHAPTER 2 – LITERATURE REVIEW

2.0 Introduction

This chapter situates this research within the existing literature. Cutcliffe (2000) contends that, as part of grounded theory methodology, a literature review should be avoided prior to commencement of a study to ensure that the nature of the study is inductive and bias is minimised. However, the researcher is not naive to this study's intention having been involved in hospital employed nurse educator and continuing development activities for twenty years. Therefore, to minimise the potential for researcher bias, a preliminary activity for this study included an initial review of the literature. This review assisted in identifying the current level of knowledge that exists to provide a rationale for the need for the proposed research (Smith & Biley, 1997). Appraisal of the literature has been considered an important initial activity as duplicating knowledge in the subject area would be both ineffective and inefficient. The initial review of the literature identified a paucity of information related to the research focus, which provides further confirmation of the importance of this work. Given the lack of research focus data, older relevant literature sources have been used where appropriate.

Additionally, in line with the grounded theory method a further, secondary, literature review was undertaken in conjunction with data analysis and following the generation of theoretical understandings (Strauss & Corbin, 1998). This review allowed for examination of additional existing research in respect to findings.

The chapter contextualises the nurse educator in Australia and reviews the international and national research literature with either a direct or indirect relationship to the study. The initial section discusses continuing professional education/development and learning in the workplace. The next section examines the international and national context of nursing education. Following this a discussion of the range of issues related to Australian standards, competencies and preparation for the role is provided to assist in situating and justifying the proposed research.

2.1 Continuing Professional Education/Development

In broad terms, continuing professional education may be defined as "the process of engaging education pursuits with the goal of becoming up to date in the knowledge and skills of one's profession" (Weingand, 1998, p. 4). The terms 'professional education', 'professional development', 'continuing education', 'continuing professional development' and 'lifelong learning' have been used interchangeably (Quinn, 2000). CPD has been recognised by adult educators as an important area of study and practice since the 1960s (Cervero, 1988; Houle, 1980; Queeney, 2000). CPD is viewed as maintaining a professional's currency or advanced knowledge of scientific and practice-specific knowledge and skills, which makes the individual professional desirable to organisations that need the expertise of specific professionals (AHPRA, 2010; ANMC, 2009; Houle, 1980; Morgan, Cullinane & Pye, 2008; Slusher, Logsdon, Parker, Rice & Hawkins, 2000; Todd, 1988; Weingand, 1999). Sjukhusläkaren (2005) claims that the aim of CPD is the development of not only the competence of the professional, but also of the personal, professional and social skills of the individual. In the mid-1980s Apps (1985) argued that the employer had a responsibility to provide a learning environment that supports career development, remedial education, self-directed learning and coping with change. This perspective is still current and in recent years CPD is not only considered essential for all health care workers but has become a requirement for Health Professional registration maintenance in Australia (AHPRA, 2010; Gould et al., 2007; Metcalf, 2001; Morgan et al., 2008; Queensland Health, 2010b).

CPD is viewed as a long-term process that includes opportunities and experiences systematically planned to promote growth and development in the profession (AHPRA, 2010; ANMC, 2009; Fahey & Monaghan, 2005; Ganser, 2000; Morgan et al., 2008; Queensland Health, 2010b). This may include experiences that are formal (e.g. workshops, professional meetings, mentoring) or informal (e.g. reading professional publications, attending conferences) (AHPRA, 2010; ANMC, 2009; Ganser, 2000; Metcalf, 2001). CPD needs to be a well-organised activity that is grounded in knowledge and scientific evidence rather than in local tradition. According to Murphy and Calway (2008, p. 425), "CPD programs should foster development of a learning culture which encourages continual growth of knowledge

and the professional's ability to apply that knowledge." CPD providers often assume that the simple transmission of information in the educational setting will influence practice and yet the literature reveals research results on the effect of CPD on experiences and behavioural change have not been consistent (Gould et al., 2007; Jantzen, 2008; Ryan, Campbell & Brigham, 1999; Slusher et al., 2000).

It is well argued that knowledge and professional practice interact (Calman, 2000; Daley, 2001; Gallagher, 2007; Morgan et al., 2008). CPD participants, therefore, can be viewed as life-long interactive learners who engage in context-related learning that should facilitate change and the development of new beliefs, and contribute to a culture of learning with a focus on reform of the professional group rather than just skills training (Billett, 2004; Cochran-Smith & Lytle, 2001; Ganser, 2000; McLaughlin & Zarrow, 2001; Morgan et al., 2008; Murphy & Calway, 2008; Young & Patterson, 2007).

According to G. Murphy et al., (2008), the design of CPD requires a focus on problems with objective repetitive solutions to build knowledge, skills and awareness. It is obvious, however, that the most effective CPD model will vary in content and context. Thus there is strong support for the identification of the need for, and benefits of, CPD from a broad and professional perspective (AHPRA, 2010; ANMC, 2009; Calman, 2000; Daley, 2001; Gallagher, 2007; Jantzen, 2008; Metcalf, 2001; Morgan et al., 2008).

Entry into professions such as medicine, dentistry, nursing and teaching require demonstration of proficiency through practice-oriented learning and registration (APHRA, 2010; G. Murphy & Roberts, 2008; Queensland College of Teachers (QTC), 2011). A review of the continuing professional education literature pertaining to teaching and nursing in particular, but also to dentistry and medicine, indicates that continuing professional education is considered essential in order to keep pace with constant professional and organisational changes (APHRA, 2010; ANMC, 2009; Challis, 2001; Davis, 2003; Gould et al, 2007; Harden & Crosby, 2000; Lombard, 1990; Morine-Dershimer, 1989; Williams, 2010). Similarities across professions can be seen in core skills required of staff who are undertaking roles in staff development and/or continuing professional development such as

interpersonal, role modeling, facilitation, assessment, research and professional knowledge and credibility. While the demonstration of competence was required for each of these professions (APHRA, 2010; ANMC, 2005; QTC, 2011) the skills identified for nursing, medical and dentistry education included clinical competence, which is not a requirement in many other professional groups (ANMC, 2005; Challis, 2001; Daley 2001; Davis, 2003; Harden & Crosby, 2000; Jantzen, 2008; Lombard, 1990; Murphy & Roberts, 2008; Ross & Stenfors-Hayes, 2008). The latter area imposes an extra dimension of skill development and CPD requirements where inadequate skill development and CPD participation can be life threatening in the clinical setting. The medical and nursing profession each have well-defined post graduate (CPD) specialisation programs which advance professional capabilities through a combination of technical content and work-related practice.

Literature related to CPD for school teachers makes no reference to roles comparable to that of the nurse educator; however, support by mentors features regularly (Beaty, 1998; Beutel & Spooner-Lane, 2009; Jones & Straker, 2006; Martinez, 2004; Morine-Dershimer, 1989). Provisional registration of school teachers in Queensland requires an accredited course of undergraduate study, participation in induction and supported development, a minimum of 200 days (1,000 hours) of teaching and demonstration of requisite professional standards (QCT, 2011). Full registration of school teachers in Queensland requires that teachers meet professional standards, abilities, experience and knowledge, and provide evidence of 30 hours of CPD (QCT, 2010). The requirements for maintaining full registration for a Queensland school teacher are similar to those for registered and enrolled nurses, with a specified amount of annual CPD.

Nursing has no provisional registration requirement. New graduates entering the workplace irrespective of participation in graduate programs do not experience the same level of support. They are often required to ‘hit the ground running’ and allocated full patient workloads with minimal supervision within a short period of commencement in the workplace. In addition, nurse educators have no registration obligations additional to those of any registered nurse and nor are they required to meet any specific nurse educator professional standards or to comply with any specified minimum teaching hours.

A review of medical education identified that, historically, medical education had little contribution from experienced facility-employed educator positions with clinicians expected to undertake the teaching role (Challis, 2001; Harden, 2002; Harden & Crosby, 2000; Ross & Stenfors-Hayes, 2008). Training programs for doctors who teach and for those in staff development-type positions appear to be increasing; however, most programs relate to students, junior doctor support and mandatory CPD requirements (Challis, 2001; Davis, 2003; Harden & Crosby, 2000; Lake & Hamdorf, 2004; Ross & Stenfors-Hayes, 2008). Positions similar to nurse educators were not identified and in some instances coordination of and responsibility for professional development programs were undertaken by administration officers or others from a non-medical background (Challis, 2001).

The number of medical staff and students is far less than nursing and midwifery staff and students and thus the models of support and clinical supervision differ. Medical students are aligned to a medical team that provides continual supervision, and support for the entire period of allocation. Because of the larger numbers, the support model for student nurses often has the student allocated to a different experienced registered nurse each shift of the clinical placement period. The extent and availability of support and supervision for newly employed and ongoing registered nurses are not consistent across, and within Queensland Health facilities (Queensland Health, 1999, 2005a, 2010a).

Since March 2010, medical practitioners in Australia engaged in any form of medical practice have been required to participate in CPD that is relevant to their scope of practice in order to maintain, develop, update and enhance their knowledge, skills and performance and to ensure that they deliver appropriate and safe care (AHPRA, 2010). Medical practitioners with full registration are required to complete either annual CPD as prescribed by college standards or 50 hours per year determined by the Medical Board of Australia (2010). Medical practitioners also have registration requirements, encompassing induction, CPD and supervised practice, which need to be met prior to attaining full registration (AHPRA, 2011).

Since July 2010, in order to maintain registration, all other registered health professional practitioner groups (nursing and midwifery, chiropractic, dentistry, optometry, osteopathy, pharmacy, physiotherapy podiatry and psychology) in Australia are also required to participate in and provide evidence of annual CPD commensurate with the health professional practitioner group standard and specified hours (AHPRA, 2010). In Queensland, since 2007, allied health practitioner groups have negotiated protected education time and industry-based educator/training positions with some similarity to nurse educator positions (Queensland Government, 2010).

CPD is recognised internationally by many professions as a core element of the ongoing development and maintenance of professional expertise (Daley, 2001; Morgan et al., 2008; Murphy & Calway, 2008). However, it also appears that CPD is effective only to the extent that it is implemented in practice with outcomes that can be measured (Draper & Clark, 2007). Unfortunately, while a number of studies have evaluated continuing professional development/education, these have tended to focus on processes and teaching strategies rather than on direct impact on practice or how staff developers or facilitators of CPD have contributed to the needs of the profession.

2.1.1 Learning in the Workplace

Workplace learning is increasingly recognised as significant in the contemporary workplace, with employers acknowledging that organisational performance capability is directly related to employees' learning ability (Billett, 2001, 2004; Mathews, 1999; Murphy & Calway, 2008; O'Connor, 2004; Schoonbeck & Henderson, 2011; Scribner, 1999). For this reason, learning is viewed as an essential component of everyday work (Boud & Garrick, 1999; Mathews, 1999; Schoonbeck & Henderson, 2011).

Billett (2004) considers that everyday participation in work tasks provides opportunities for learners to generate tentative solutions to job-related tasks and then to attempt to secure those solutions. Billet (2004) asserts that this results in knowledge being indexed and organised in ways that are purposeful in terms of the successful securing of workplace goals, and argues that a guided approach to

learning provides the opportunity for learners to develop increasingly mature approximations of the procedures required to be successful in these tasks through a process of testing, and modifying their approximations. Billett (2004) and Young and Patterson (2007) profess that the active learner-focused nature of engagement in workplace activities induces learners into goal-directed activity conducive to accessing higher orders of procedural knowledge and deeper conceptual knowledge, as well as the development of more specific forms of knowledge. The assertion (Billett, 2004; O'Donoghue & Maguire, 2005; Young & Paterson, 2007) is that active engagement in workplace learning is particularly useful for the transfer of knowledge to other circumstances and assists with adaption of new stimuli to exiting knowledge.

Billett (2001, p. 39) also argues that "learning and working are interdependent" and that work practices provide, guide and structure activities in ways that influence the learning and knowledge required for performance at work where experiences are neither totally informal, unstructured nor incidental. Billet (2001) points out that the experiences of workplace learning are structured by the requirements of work practices rather than those of the higher education sector. Billet (2001) maintains this occurs because workplace activities and the guidance and support contributing to learning are different, being more likely to be authentic, transferable, purposeful and central to the workplace. As such this form of learning is unlikely to be replicated in educational institutions or through substitute means. Consequently, key contributions to workplace learning are located in engagement in activities and in direct and indirect guidance (Scribner, 1999; Schoonbeck & Henderson, 2011). Workplaces are more than just physical environments; they are social systems with activities premised on interactions with others as components of a particular work practice (Billett, 2004; O'Connor; 2004; O'Donoghue & Maguire, 2005; Schoonbeck & Henderson, 2011; Scribner, 1999; Shulman, 2002).

Both Billett (2001) and Moore (1986) argue that absence of experts to provide guidance will likely inhibit the quality of work-place learning. They claim that without the support of experts in the workplace, transfer of knowledge may also be limited, particularly if there is reduced effective access for physical and/or geographic reasons (Billett, 2001; Moore, 1986). The perception of learners of

'expertise' and creditability is also important as they are the determiners of what they learn and value. Furthermore, Billet (2001) maintains that the ability to develop expertise and to generate solutions in the workplace needs, in addition to direct and indirect 'expert' guidance and support, organisational interventions and maintenance strategies. Billett (2004) also identifies limitations associated with learning in the workplace such as inappropriate learning, lack of access to activities, guidance and understanding of workplace goals, the reluctance of workers to participate, demarcation, distrust, isolation, and the absence of a culture of support.

Knapper (2001) similarly argues that to meet challenges such as technology, social changes, enhanced expectations and work volume, workplaces will increasingly require approaches to learning that stress depth in the sense of contextual understanding and integration of new knowledge with existing ideas to solve complex novel problems. According to Debreczeny (2003), the effectiveness of the learning that takes place in the workplace can be enhanced by the creation of a supportive climate through the encouragement of the individual. A number of authors (Mathews, 1999; O'Connor, 2004; Schoonbeck & Henderson 2011) support this assertion, claiming that a successful workplace learning environment needs to have an organisational climate which supports the philosophy of learning promoted by the organisation. This entails the culture, structure, systems, technology and people supporting the workplace learning services, along with the organisation that provides the necessary resources and encouragement.

There is often an unwillingness to allocate resources to workplace learning as resultant tangible quantitative benefits to the organisation are not clear (Forster, 2005; Mathews, 1999; Queensland Health 2010a; Schoonbeck & Henderson, 2011). Organisations need staff at all levels to be more self-sufficient, resourceful, creative and autonomous, as these behaviours facilitate higher strategic functioning of staff, which, in turn, makes organisations more productive and competitive (Mathews, 1999; Schoonbeck & Henderson, 2011; Williams, 2010). While the exact relationship of workplace learning and CPD to organisational traits and challenges has yet to be definitively established, there is evidence to suggest that this learning plays a role in the modeling of learning organisations, in better perceived quality of care, and in lower patient mortality rates (Aiken, Smith & Lake, 1994; Mathews,

1999; McCormack & Slater, 2006; Williams, 2010). On this basis, the outcomes of reasoned workplace learning benefit both the individual and the organisation.

2.1.2 Nursing Context

There appears to be some agreement in the literature about the aim of continuing education for the nursing profession; however, there are divergent opinions over the form of that education (Barriball, White, & Norman, 1992; Brunt, 2003; Fahey & Monaghan, 2005; Furze & Pearcey, 1999; Gallagher, 2007; Lawton & Wimpenny, 2003; Williams, 2010). What can be gathered is that there are multiple dimensions to continuing professional development and that individual aspects influence nurses' perceptions of this issue (Gallagher, 2007; Hughes, 2005; Morton et al., 2008; Quinn, 2000). Nonetheless a shared intent of CPD appears to be assisting nurses to "critically assess their clinical practice and identify their own continuing education needs" (Barriball et al., 1992, p. 1129). Although this intent was postulated in the early 1990s it remains congruent with current views on CPD in the nursing context (Gallagher, 2007; Griscti & Jacono, 2006; Hallin & Danielsson, 2008; Lawton & Wimpenny, 2003; Murphy & Calway, 2008; Williams, 2010). Despite variations in employer support for continuing education, professional nursing associations and regulatory authorities consistently emphasise its importance in maintaining professional competence and ongoing learning and development (AHPRA, 2010; ANMC, 2009; American Nurses Association, 2002). The benefits of continuing education in health care have been identified as enhanced staff satisfaction and improvement in services and in patient outcomes (Kramer & Schmakenberg, 2004; Morton et al., 2008; Wilkinson, Challis, Homa, Parboosingh, Sibbald & Wakeford, 2002; Williams, 2010); increased recruitment and retention capability (Aiken, Clarke, Sloane, Schalski, Busse, Clarke, Giovannetti, Hunt, Rafferty & Shamian, 2001; Gould et al., 2007; Kramer & Schmakenberg, 2004); and improvement and promotion of quality patient care, reduced length of stay, and incidence of complications (Aitken & Patrician, 2000; Schostaka, Davisb, Hansonc, Schostakd, Browne, Driscollf, Starkeg, & Jenkinsh, 2010). Levitt-Jones (2005, p. 232) notes that "continuing education has the potential to develop attributes such as analytical ability, critical thinking, communication, teamwork, flexibility and the ability to adapt to change". More work is needed, however, to show the 'exact causal effect' between continuing education and apparent benefits (McCormack & Slater, 2006; Williams, 2010). Nonetheless, continuing education is viewed as a

core mechanism to assist nurses to remain aware of the latest research and evidence on which to base practice and to obtain requisite corresponding industry-related skills in order to work effectively within the current health care environment (Gibson, 1998; Levitt-Jones, 2005). Yet, just as nurses have a professional responsibility to engage in continuing education, an organisation has an obligation to provide access and supporting infrastructure that will foster continuing education as integral to the culture (Forster, 2005; Levitt-Jones, 2005; Ridge, 2005).

Irrespective of perceived benefits, McCormack and Slater (2006) assert that, even if continuing education is viewed as central to career progression, alone it is not enough to establish and support a culture of learning in an organisation. Rather, it is the interactive relationship between continuing professional development, organisational structures, and processes that help foster an environment conducive to ongoing development and learning. Variables, including leadership style, communication processes, a culture's receptiveness to change, involvement in decision making, and the nature of the professional relationships, are considered factors that define an organisational culture and the way continuing professional development might be supported or misdirected (Levitt-Jones, 2005; McCormack & Slater, 2006; Ridge, 2005; Williams, 2010).

Ridge (2005) and Williams (2010) also support the premise that nurse leaders need to adopt the notion of building an organisational culture of continuous learning where staff are guided, supported and fostered to function at an optimal level without fear of retribution. The challenge for leaders is how to engage staff in development initiatives that encourage them to acquire and embed knowledge into the social composition of the organisation. However, the concept of a learning organisation, defined by Probst and Buchel (1997, p. 17, cited in Yun & Reigeluth, 2005, p. 34) as "learning by a social system", is a goal to be followed rather than a state to be achieved, as learning is continuous. Griffiths (2002) also considers that ongoing education will assist in minimising the stress and anxiety associated with change. Because continuing professional development is considered to be a crucial part of nursing professionalism, it is thus deemed important that nurse leaders and educators collaborate through these activities to support staff in lifelong learning.

Jarvis (2005) asserts that continuing professional development should not be an afterthought but rather needs to consider both the complexity and the sophistication necessary to make it effective and relevant to practice. The profession acknowledges that professional practice might be at risk in an environment driven by clinical imperatives, public expectations and workforce shortages (Underwood, Dahlen-Hartfield & Mogle, 2004). It is also acknowledged that these factors motivate hospital employed nurse educators to create innovative ways to train and retain competent nursing staff. Challenges include developing programs that support professional growth and excellence and provide health care organisations with ways to demonstrate that employees have the knowledge and skills necessary to achieve organisational objectives and goals (Robinson, Flynn, Canavan, Cerreta & Krivak, 2006). Knowles (1990) argues that all teaching and learning should be conducted according to the best researched principles of adult education, building on past experiences and supporting the application of what is learned to existing life experiences. Jarvis (2005) also maintains that programs should be systematically produced in direct response to practice-related problems. Providing access for all staff to continuing professional development, irrespective of individual motivation provides the opportunity to develop own interests, and to keep abreast of current trends and developments (Jarvis, 2005; Robinson et al., 2006).

A number of authors (Christiansen, 2011; Conway & Elwin, 2007; Gaberson & Oermann 2007; Jarvis, 2005; Queensland Health, 2010a; Sayers, DiGiacomo & Davidson, 2011) argue that nurse educators need to be highly skilled professionals who have been educationally prepared to effectively fulfill the multifaceted nature of the nurse educator role: being considered a 'good clinician' does not take account of the teaching and learning, leadership, change management and organisational aspects of the role. Three factors to be considered are the nurse educator's role in supporting the development of a self-directed lifelong learner rather than fostering a pervasive culture of nurse educator dependency, how this role needs to keep evolving and working in partnership with colleagues, and how it contributes to the continuing development of the profession.

2.2 The Nurse Educator

It is argued that nurse educators and similar positions employed in hospitals play a vital role in the continuing and professional development of nursing staff (Adrianne, 1996; Christiansen, 2011; Conway & Elwin, 2007; Hughes, 2005; Lepine & Ahola-Sidaway, 2000; Mateo & Fahje, 1998; Queensland Health, 2010a; Ridge, 2005; Sayers & DiGiacomo 2010; Sayers, DiGiacomo & Davidson, 2011). One of the perceived challenges facing nurse educators working in health care environments is the need to develop skills for managing the complexity that presently is a feature of health services (Conway & Elwin, 2007; Mottola, 1996; Queensland Health, 2010a; Sayers & DiGiacomo 2010; Sayers, DiGiacomo & Davidson, 2011). Continuing professional development activities in nursing 'do not stand in a vacuum', but are influenced by culture and politics from within and outside nursing (Guy, Taylor, Roden, Blundell, & Tolhurst, 2010; Queensland Health, 2010a; Sayers & DiGiacomo, 2010; Sayers, DiGiacomo & Davidson, 2011; Shanley, 2004). Consideration of the context of the workplace, the nature of practice, and the connections between what it is that a hospital nurse educator does and how work is conducted in the workplace is important (Conway & Elwin, 2007; Forster, 2005; Queensland Health, 2010a). As determined by Queensland Health (2010a), educators are often unable to control how programs are implemented or how learning occurs in the workplace. However, they are able to consider their knowledge and involvement by being familiar with strategic organisational and work unit issues and for developing resources and programs that support work practice changes (Queensland Health, 2010a).

Currently the nursing profession, both in Australia and overseas, is faced with numerous challenges: an aging workforce, growth in technology, increasing fiscal demands on the health care system and on national and specific specialty shortages, and role creep and substitution (Appel & Malcolm, 1998; Department of Health, 2004; Gallagher, 2007; Glasper, 2012; Guy et al., 2010; Heath, 2002; Queensland Health, 2010a). Additionally, there is an ongoing perception that new graduates are not work ready and require additional transition support to function effectively within the workplace (Heath, 2002; McKenna, Thompson, Watson & Norman, 2006; Queensland Health, 2006a, 2010a). These challenges translate into

work environments in need of differing staff development programs and continuing professional development (NHS, 2003; Queensland Health, 2007b, 2010a, 2010b).

There appears to be little analysis of the role of the nurse educator (Christiansen, 2011; Conway & Elwin, 2007; Sayers & DiGiacomo, 2010; Sayers, DiGiacomo & Davidson, 2011; Ramage, 2004; Squires, 1999). The nurse educator role has been ascertained to be complex and multifaceted in nature but largely ill defined, with priorities given to the different functions of the workload remaining unclear (Cahill, 1997; Conway & Elwin, 2007; Sayers & DiGiacomo, 2010; Sayers, DiGiacomo & Davidson, 2011). With the multidimensional nature of the role and the ever changing expectations it has been concluded that role ambiguity easily arises as nurse educators are expected to provide clinical, organisational and professional support in an ever-changing environment (Conway & Elwin, 2007; Hardy & Hardy, 1988; Queensland Health, 2010a; Schoonbeck & Henderson; 2011). Congruence between nursing staff understanding and learning needs, and the nurse educator's perception of nursing practice and views of learning and development is important, as these influence what nurse educators teach and facilitate (Conway & Elwin, 2007; Queensland Health, 2010a; Squires, 1999).

There are a number of international studies of nurses in nursing education roles (Ashton, 2012; Barger & Bridges, 1987; Cahill, 1997; Camiah, 1998; Christiansen, 2011; Clifford, 1993; Day, Fraser, Aston, Cooper, Hall, Hallawell & Narayasasamy, 1998; Forrest, Brown & Pollock, 1996; Griscti, Jacono & Jacono, 2005; Just, Adams & De Young, 1989; McCormack, & Slater, 2006; Rampage, 2004; Salsali, 2005; Sayers, DiGiacomo & Davidson, 2011). Studies predominately investigate the clinical education role in relation to the teaching and support of undergraduate student nurses, not of registered or enrolled nurses working in health care facilities. While similarities with some aspects of the Australian nurse educator role appear evident it is unclear if positions in the United States primarily focus on hospital nursing staff, as in Queensland, or provide services to additional groups. Australian literature relates primarily to undergraduate student education and specific clinical nurse teacher or educator roles (Conway & Elwin, 2007; Forbes, 2006; Lee, Cholowski & Williams, 2002; Pelletier, Duffield, Adams, Nagy, Crisp, & Mitten–Lewis, 2000; Sayers & DiGiacomo, 2010; Sayers, DiGiacomo & Davidson,

2011). No literature has specifically addressed the Australian hospital employed nurse educator contribution to the continuing education needs of the profession.

While Clifford (1992) identified some common trends between the United States, Canada and the United Kingdom (UK) with respect to literature exploring the role of the nurse teacher, she suggested caution as the educational background and preparation for these roles differs, making direct international comparison difficult. A recent Canadian study made the same points (Christiansen, 2011).

A grounded theory study comprising 28 in-depth interviews with nurse participants, undertaken by Ramage (2004) in the UK, explored the teacher's role in clinical practice and identified two emerging themes: difficulty in negotiating multiple roles and being effective in the teaching role. There were no consistent definitions, just varied perceptions of the purpose and value of the role. A recommendation of this study was that further research be undertaken in relation to how roles impact on students and on nurses working in practice. While Ramage (2004) only focused on the perspective of nurses in education roles, the current study was inclusive of nurse educators, line managers and clinicians.

Studies from other countries (predominately Canada, UK and USA) (Adrianne, 1996; Ashton, 2012; Lepine & Ahola-Sidaway, 2000; Mateo & Fahje, 1998; Ridge, 2005) focus predominately on how to support staff development/continuing education roles and programs, or how to evaluate programs, strategies and support approaches for staff in these roles. In these studies, the common themes around the teaching and educative role were found to include, but were not limited to, clinical credibility, effective teaching skills, facilitator of learning and learner development, and effective communication and leadership abilities (ANA, 2002; Billings, 2003; Gillespie & McFetridge, 2006; Queensland Health, 2006a, 2010a; Shanley, 2004). Studies do not describe fully such aspects as administration activities, performance issues, or the nurse educator role as identified by nurse educator job descriptions in Queensland (Queensland Health, 2005b, 2006b, 2010a). Neither do they address the position's contribution to continuing development needs.

In 1990, Lombard undertook a study comprising interviews, critical incident technique and member checks in two USA hospitals, with the aim of describing the characteristics of the effective nursing staff development instructor in the hospital setting. Six categories of characteristics and behaviours were identified: teaching strategies/skills, presentation skills/styles, nursing competence, planning and arrangements, activities outside the classroom, and interpersonal/personality. Neither the effectiveness of the role in the hospital setting nor the contribution of the role to continuing education needs was explored.

While the characteristics identified by Lombard (1990) are still current it is also argued (Christiansen, 2011; Davis, Stullenbarger, Dearman & Kelly, 2005; McCormack & Slater, 2006; Sayers, DiGiacomo & Davidson, 2011; Williams, 2010) that those working in nursing education roles in hospital settings need to continually reflect and refocus in order to facilitate the development of staff, especially in the current context of health care, with its increasing financial constraints and climate of organisational redesign. Casualisation of the nursing workforce is a phenomenon increasingly impacting on nurse educator services and resources: historically, nurse educator numbers and resources were determined by full time equivalent nursing staff numbers. However changes in technology, mandatory, requisite training and continuing education services need to address the total number of staff ('headcount'). Consequently, there may be a disparity between the supply of nurse educator services and demand that may not be factored into budgets and associated resources. It is also acknowledged that the emphasis on specific aspects of the role of a nurse educator vary according to context (Conway & Elwin, 2007; Davis et al., 2005; Manning & Neville, 2009; Queensland Health, 2010a; Sayers, DiGiacomo & Davidson, 2011). Hence, how nurse educators undertake their roles will be informed by their perceptions of nursing practice, teaching and learning, clinical context, service needs and organisational priorities (Ashton, 2012; Christiansen, 2011; Conway & Elwin, 2007; Manning & Neville, 2009; Sayers & DiGiacomo, 2010; Sayers, DiGiacomo & Davidson, 2011; Shanley, 2004).

The role of the 'staff developer' is to encourage a holistic approach to learner development (Ashton, 2012; Challis, 2001; Conway & Elwin 2007). In practice this probably requires them to act as a 'go between' in several spheres, trying to fit development and training activities into clinical schedules, and within work environments that are under pressure. Consequently a nurse educator, like any teacher or facilitator of learning, must understand the context of the environment and the varied needs of individuals with whom they are working, and must provide appropriate learning opportunities, especially as the trend in nursing education is to blend practice and education roles (Christiansen, 2011; L. McKenna, 2003; Shanley, 2004; Williams, 2010). Concerns have been expressed, however, that some nurse educators are still inclined to view the participant as a passive consumer of knowledge (Forster, 2005; Freire, 2000; Queensland Health, 2010a). The perception is that they are not learner-centered and focus on themselves and their teaching strategies rather than on facilitating the learning, development and engagement of the learner/program participants (Queensland Health, 2010a). Challis (2001, p. 270) contends that the role of the "staff developer whose job it is to implement evidence and research findings into practice" is often difficult, particularly as teaching is regularly seen as a lesser priority than meeting the immediate needs of patients, complying with managerial pressures and performing clinical research.

It is argued that nurses in staff development have a crucial role in helping other nurses negotiate their way through challenging, changing health care environments (Ashton, 2012; Conway & Elwin, 2007; McCormack & Slater, 2006; Shanley, 2004). Shanley (2004) and Gallager (2007) claim nurse educator work is complex and always evolving given that they are expected to guide and support in dynamic environments not geared to learning as a first priority. The hospital employed nurse educator assists in identifying resources; developing, implementing and evaluating the learning needs of the individual; attempts to use the infrastructure of the organisation to foster relationships; and supports ongoing development that is meaningful. A number of authors (Gould, Berridge, & Kelly, 2006; Williams, 2010) assert that education and training programs offered should be selected and implemented to support staff in developing and applying knowledge and skills needed to meet the requirement of the work environment and their current role.

2.2.1 The Nurse Educator in Australia

There has been confusion regarding the roles and responsibilities of hospital employed nurse educators in most Australian states since the transfer of undergraduate nursing training to the higher education sector in the 1980s–1990s (Conway & Elwin, 2007; Muir, 1981; Sayers & DiGiacomo, 2010; Sayers, DiGiacomo & Davidson, 2011; R. Smith, 1999). Prior to the full transfer of nurse education to the higher education sector there was a mix of roles undertaken by nurse educators employed in hospitals (Conway & Elwin, 2007; Degeling, Hill, Kennedy, Coyle & Maxwell, 2000; Sayers & DiGiacomo, 2010; Sayers, DiGiacomo & Davidson, 2011). The predominant nurse educator role focus was hospital training to achieve registration or enrolment to a certificate award level. Nurse educator role, numbers and concentrated support for CPD, and workplace learning were limited.

Following the transfer of nursing education to the higher education sector the role of nurse educator working in the majority of Australian states, including Queensland, did not reflect the roles reported by their American and British counterparts (Barger & Bridges, 1987; Cahill, 1997; Camiah, 1998; Clifford, 1993; Conway & Elwin, 2007; Day et al., 1998; Forrest et al., 1996; Griscti et al., 2005; Just et al., 1989; Salsali, 2005; Sayers & DiGiacomo, 2010; Sayers, DiGiacomo & Davidson, 2011). In Australia, the role emerged as a multi-dimensional staff development/CPD role with emphasis on facilitating the clinical, organisational and professional development of the registered and enrolled nurse rather than on undergraduate clinical teaching and support (Conway & Elwin, 2007; Queensland Health, 2007a, 2010a). The position fosters and coordinates the development, delivery and evaluation of CPD programs, to enable nurse clinicians to provide evidenced-based care that meets relevant professional practice standards (ANMC, 2006a, 2009; Conway & Elwin, 2007; Queensland Health, 2005a, 2010a). Incumbents are expected to maintain clinical relevance and attain educational expertise to provide context specific workplace support for nursing staff, and to meet changing organisational and staff expectations with minimal disruption to clinical services (Queensland Health, 2008, 2010a).

Nurse educators employed within Queensland Health facilities do not routinely support or facilitate undergraduate clinical placements or the other education needs of undergraduate nursing students (Forster, 2005; Queensland Health, 2010a). That role is undertaken by clinical nurse specialists termed 'clinical facilitators' (Forster, 2005; Queensland Health, 2010a). These individuals may comprise hospital employed staff or higher education sector staff working in a contract position, for the period of student nurse clinical placement. Joint faculty–hospital appointments for this role are not the dominant model for under or post graduate clinical education.

Subsequent to Forster (2005), Queensland Health has provided recurrent funding for an additional sixty public sector hospital employed nurse educator positions. Prior to this, the National Review of Nursing Education, *Our Duty of Care* (Heath, 2002, p. 83), determined that "nurse educators, whether in academia or practice environments, are essential in assisting other nurses and student nurses to develop high-level competencies and their theoretical underpinnings". The report noted strategies for ongoing learning and transition but provided little if any reference to the hospital employed nurse educator role in facilitating the occurrence of these activities. Indeed, clinical education in the report primarily relates to undergraduate students with no reference made to ongoing clinical development or upskilling for the nursing workforce (Heath, 2002). Upskilling, "training or education that provides new or additional knowledge or skills to enhance workforce capacity and capability" (Queensland Health, 2007a, p. 2) but which excludes mandatory or requisite skills, is considered a major factor in reducing risks and enhancing scope of practice (Forster, 2005; Queensland Health, 2007a, 2007b).

Since the introduction of national registration for all health professionals in Australia (July 2010) and the required evidence of minimum annual CPD hours (Nursing, 20 hours) (AHPRA, 2010; Nursing & Midwifery Board of Australia, 2010), the hospital employed nurse educator role that includes fostering, coordinating, developing and delivering CPD (Queensland Health, 2005a, 2010a) has been reported as changing emphasis and workload (Queensland Health, 2010a). Although individual nurses are accountable for providing evidence of attaining CPD hours (Nursing and Midwifery Board of Australia, 2010) and standards (ANMC,

2005; 2009), organisations expect that nurse educators undertake a resource, monitoring and support role with respect to this requirement (Queensland Health, 2010a, 2010b).

2.2.2.1 Standards and Competencies for Australian Nurse Educators

There is a lack of clear guidelines and specific standards of practice for nurse educators in Australia. Variations in job description key skills and attributes exist statewide and nationally, as does the requirement for academic preparation for the role. The competence emphasis for the hospital employed nurse educator in many practice areas is primarily on clinical competence (ANMC, 2005).

The Australian Nurse Teacher's Society (ANTS) advocates that the competence of teachers of nursing is an essential issue for the profession, employers, government and the community and has developed competency standards for Nurse Teachers (ANTS, 1996, 2010). However Guy, Taylor, Roden, Blundell and Tolhurst (2010, p. 237) caution that these competencies "… may not reflect all the nurse teacher roles in Australia" and that the difference in employment nomenclature between states may cause confusion and role variation in differing contexts.

In Queensland Health facilities the term nurse teacher is not an award classification and assessment against common standards (e.g. ANTS, 1996, 2010) does not occur regularly as part of the nurse educator annual performance appraisal and development review. Instead discrete job descriptions responsibilities and performance indicators are used to determine satisfactory performance. Anomalies in role expectations in various contexts may lead to grievance and discrimination claims by nurse educators as a result of differing performance standards and evaluation expectations (Forster, 2005; Queensland Health, 2010a).

In the USA the National League for Nursing (NLN) (2005) has developed Core Competencies of Nurse Educators. Their eight broad competencies, with task statements, have been used to provide direction for the development of graduate programs that prepare nurse educators, providing a framework of essential

knowledge, skills and attitudes relevant to the educator role in the USA. These USA competencies also form the basis for a certification program for academic nurse educators, a strategy for establishing nursing education as a specialty area of practice (NLN, 2008).

2.2.2.2 Nurse Educator Preparation and Development

Although the literature includes much research on the development of teachers and educators, little has been formally applied to the development of nurse educators within hospitals and there is little information that directly relates to specific educational programs training nurses for a hospital employed nurse educator role (Benner, 1984; Conway & Elwin, 2007; Christiansen, 2011; Lane, 1996; Sayers, DiGiacomo & Davidson, 2011; Zapp, 2001). No publications referred to specific requirements for formal training of hospital employed nurse educators in Australia. Reports indicate that most nurse educators in Queensland Health acquire their teaching experience 'on the job' and as preceptored by other nurse educators (Queensland Health, 2006a, 2010a).

McKenna (2003) concluded that, traditionally, nurses were selected as teachers or staff developers based on their clinical expertise rather than their knowledge and abilities as educators of adults and generally had little if any training before commencing in the role. This conclusion is consistent with later assertions (Conway & Elwin, 2007; Christiansen, 2011; Jarvis, 2005; Sayers, DiGiacomo & Davidson, 2011) that, despite being a 'good clinician', it is difficult for a nurse to translate into a nurse educator role without preparation for the teaching and learning, leadership change management and organisational aspects of that role. Siler and Kliener (2001) argued that there is little truth in the popular notion that 'anyone can teach' and concluded that new nurse educators often have trouble adapting to the demands of their role, resulting in stress and an impaired ability to function effectively. Similarly, Challis (2001) and Christiansen (2011) found that those new to nursing education positions are often expected to learn the role through a process of 'osmosis'.

Participation by new nurse educators in formal courses leading to recognised awards will depend on the support, encouragement and expectations of colleagues and on the personal motivation of the individual (Siler & Kliener, 2001). A number of authors (Manning & Neville, 2009; Neese, 2003) challenge the concept that knowledge of subject matter is all that is needed to be an excellent teacher, as socialisation, supportive interaction, critical reflection, mentoring and coaching are also essential to the success of novice educators. Donner, Levonian and Slutsky (2005) claim that nurses who enter staff development/nurse educator roles with minimal preparation and support will more likely never fully appreciate full role responsibilities, in particular those related to the importance of adult learning principles and to being a facilitator of learning with a focus on the learner needs and desired outcomes. Several authors (Donner, et al., 2005; Neese, 2003) assert that if nurse staff developers are unable to support or effectively translate the principles of adult learning, engagement of the clinician in continuing education will be negatively impacted.

Some authors (Johnson, 2002; Lane, 1996) have built on the work of Benner (1984) to develop self-assessment or performance assessment tools to assess a nurse educator's ability to use the educational processes and concepts of managing staff development/CPD programs. One reported strategy was the use of a rating scale tool to determine the nurse educator's ability to perform in the role (Johnson, 2002; Lane, 1996), with each author identifying different categories and criteria to determine the nurse educator's level of expertise. However, the authors cautioned that the tools had been purpose-developed as self-assessment or development tools for a particular context, and advised limited generalisability and transferability.

The literature generally endorses adequate support, training, and the attainment of higher degrees to function effectively in the role of a nurse educator; however, these requirements vary internationally and are disregarded in some instances because, for example, of a need to fill positions due to shortages (Conway & Elwin, 2007; Christiansen, 2011; Johnson-Crowley, 2004; Krisman-Scott, Kershbaumer & Thompson, 1998; McKenna, 2003; Siler & Kliener, 2001; Trossman, 2004). In Australia, experienced nurses holding a bachelor degree occupy nurse educator positions, with post graduate degrees and/or teaching

qualifications deemed "desirable" but not required (Queensland Health, 2006b; 2010a). The absence of post graduate and/or teaching qualifications can impact on the ability of an individual to effectively fulfill a nurse educator role, particularly where the prevailing professional view or organisational culture is that specialists require post graduate qualifications and that any 'good clinician' can teach (McKenna, 2003; Siler & Kliener, 2001). Respondents to the review of the ANTS Competency Standards identified the need for clinical educators to have specialist skills in education (Guy et al., 2010). Similarly, the view expressed by participants in a Queensland Health mapping activity of those involved in education activities (Queensland Health, 2010a) was that any nurse employed in an educational role should not just have clinical expertise but should attain and maintain specialty education knowledge and skills.

2.2.2 The Clinical Nurse Educator

It has been identified that the titles 'clinical nurse educator' (Australia and North America), 'staff development educator' (North America), 'practice developer' and 'clinical education facilitator' (UK and Australia) generally refer to an 'intermediary role' concerned with the promotion and facilitation of professional development of nurses in healthcare practice (Christiansen, 2011; Conway & Elwin, 2007; Manning & Neville, 2009; Milner, Eastabrooks & Myrick, 2006). While the positions were found to be different with respect to specific objectives and overarching responsibilities, all included support for professional development of nurses and facilitation of change within the healthcare environment. There is also blurring of role boundaries among the roles of clinical nurse educator (and similarly defined roles), clinical nurse specialist, nurse educator and nurse researcher (Christiansen, 2011; Conway & Elwin, 2007; Davies, Laschinger & Andrusyzyn, 2006; Ferguson, 1996; Mackay, 1998; Manning & Neville, 2009; Mateo & Fahje, 1998; Raja-Jones, 2002; Sayers & DiGiacomo, 2010; Sayers, DiGiacomo & Davidson, 2011). ANTS (2001) found disparities in role expectations and outputs between nurse educators and clinical nurse educators; for example, clinical nurse educators are often included in clinical staff numbers and remunerated at lower level than nurse educators.

Other studies similarly acknowledged inconsistency in nomenclatures across nursing education in Australia and other countries (Christiansen, 2011; Conway & Elwin, 2007; Manning & Neville, 2009; Sayers & DiGiacomo, 2010; Sayers, DiGiacomo & Davidson, 2011). It is argued that inconsistency causes misunderstanding and contributes to a lack of role clarity and performance, since terms are used interchangeably when in fact there are differences in role purpose and expected outcomes. A number of authors (Christiansen, 2011; Conway & Elwin, 2007; Manning & Neville, 2009; Sayers, DiGiacomo & Davidson 2011) have established that the confusion in the terminology used to define roles assigned to hospital nursing education position contributing to CPD is because this role remains poorly differentiated.

Inconsistency in employment and role expectations of the clinical nurse educator position in Queensland and other identified issues (Christiansen, 2011; Conway & Elwin, 2007; Manning & Neville, 2009; Sayers, DiGiacomo & Davidson, 2011) have been experienced since the role was implemented in Queensland Health facilities in 2007.

2.3 Conclusion

The present study is grounded in issues arising from confusion around the role of the hospital employed nurse educator and sought to explore all dimensions of the role. The literature review outlined above substantiates the rationale for conducting a study on the role of hospital employed nurse educators and their contribution to the continuing education needs of the nursing profession.

It is concluded from the above that improved knowledge of the hospital employed nurse educator's contribution to contemporary practice will advance educator involvement in facilitating learning and supporting a culture of learning. It is noteworthy that, while multiple studies identify the need for organisations to support staff development and CPD, no recent works actually review the role of the hospital employed nurse educator and its contribution to contemporary practice. There is a limited body of work that considered the clinical role of a nurse educator or clinical nurse educator; however, no work has examined the combination of clinical, organisational leadership and professional elements of the role. Of

particular note is the apparent absence of any Queensland or Australian study of the role and contribution of the hospital employed nurse educator since the transfer of nursing education into the higher education sector in the early 1990s.

This chapter presented a review of the literature and identified a lack of contemporary research regarding the role of the public sector hospital employed nurse educator in Australia and a dearth of research into how the hospital employed nurse educator contributes to the continuing education needs of the nursing profession.

The following chapter addresses the research design in order to extrapolate and justify the choice of theoretical underpinnings of the study, research methodology, the selection of the population and the choice for research methods for this study. The theoretical underpinnings of symbolic interactionism are explored drawing on key concepts from the works of Mead (1934), Blumer (1969) and Goffman (1963). The grounded theory methods employed in the study are described and justified. In addition rigour considerations are examined, and relevant ethical issues addressed.

CHAPTER 3 – RESEARCH DESIGN

3.0 Introduction

This chapter explains and justifies the research design adopted in pursuit of the research purpose. The chapter commences with an overview of the research design and justification of the theoretical underpinnings of the study. The grounded theory methods applied in the study and a rationale are then addressed in detail. Importantly, while the processes of sampling, data generation and data analysis are presented in a linear format below, in the study the processes were applied simultaneously. In addition, factors surrounding rigour and relevant ethical issues are explored.

3.1 Theoretical Framework

A theoretical framework provides a philosophical foundation that justifies and gives direction and structure to a research design (Crotty, 1998; Mertens, 1998). Such a framework comprises a system of concepts, assumptions, expectations and beliefs that support and inform the research process (Maxwell, 2005). As such, a framework offers a guide to what may be used to select concepts for investigation, to research questions and to frame research findings (Corbin & Straus, 2008). To ensure rigorous research, a paradigm congruent with the researcher's beliefs about the nature of reality was considered essential. Guba and Lincoln (1994) support this view in arguing that a choice of research methodology is determined and influenced by the researcher's basic guiding belief system or world view. Essentially, the researcher's goal was to understand the actions of the social actors in the research situation, responses to those actions and the meanings people construct around their experiences. This understanding extended to the ways in which participants were influenced by their history and cultural contexts and thus how interaction and context formed their views of the world (Blumer, 1969; Glaser, 1998; Hearon & Reason, 1977).

Some controversy exists about how and whether a theoretical framework should be used in qualitative studies, due to concern that such a framework threatens the authenticity of interpretive research (Corbin & Strauss, 2008; Robson, 2002). However in practice, qualitative researchers are enlightened by existing theories that

provide sensitising concepts believed useful if considered in conjunction with theories generated from the data (Corbin & Strauss, 1996, 2008; Robson, 2002; Strauss & Corbin, 1990). Indeed a useful theory helps organise data (Corbin & Strauss, 1996, 2008; Robson, 2002; Strauss & Corbin, 1990). Theories also inform practice and assist researchers to demonstrate relationships between their field of study and those of other researchers (May, 2001). Hence it is important that the researcher considers the approach of theorists to question what is of relevant concern (May, 2001).

In this study the phenomena of interest are the perceptions of different classifications of nursing staff with respect to how public sector hospital employed nurse educators contribute to the continuing education needs of nurses employed within Queensland Health. Thus consideration of a research methodology that would provide a fit with the research question posed by the researcher led to the adoption of an interpretive approach with the underpinnings drawn from symbolic interactionism (Annells, 1996, 1997; Blumer, 1969, 1998, Mead, 1934).

3.1.1 Theoretical Perspective

3.1.1.1 Symbolic Interactionism

The theoretical basis for this study lies within an interpretive perspective (Blumer, 1969; 1998; Crotty, 1998). Interpretivism aims to generate a more in-depth understanding of specific phenomena within the normal world of participants (Crotty, 1998; Merriam, 1998) through exploration and analysis of symbols (social meanings) such as language and behaviours (Geertz, 1973). Interpretivists are concerned with understanding the meanings people give to objects, social settings, events and the behaviours of others and how these understandings, in turn, define the settings (Merriam, 1998).

In this study, symbolic interactionism provided the lens through which participant meanings around public sector nurse educator social interactions were interpreted (Merriam, 1998). The fundamental propositions of symbolic interactionism were shaped by Mead (1934) and later Blumer (1969) and the underpinnings developed by earlier theorists within the traditions of social psychology and sociology (Blumer, 1969; Glaser & Strauss, 1967). A number of

variations of symbolic interactionism have evolved including the Chicago School (George Herbert Mead, John Dewey and Herbert Bulmer), the Iowa School (Manford Kuhn and Carl Couch), the Dramaturgical School (Erving Goffman), and the Ethnomethodical School (Harold Garfinkel), each with its own intellectual origins and features (Edgley, 2003; Manning & Smith, 2010; Maynard & Clayman, 2003). However, the work originating from the Chicago School with its foundations in the pragmatist philosophies has been most prominent and is applied in this research (Burbank & Martins, 2009). Where theoretically relevant the postulations of Erving Goffman have also been drawn upon.

While the tradition of symbolic interaction is broadly drawn, a consistent focus is on how one interprets circumstances and why one course of action is chosen over another (Blumer, 1969). Mead (1934) and Blumer (1969) argued that the ways humans interact in relation to a particular situation are learned through social interaction. Thus symbolic interactionism allows a researcher to view the world and gather data through the study of symbols and meanings that operate in a group and/or setting. While not ignoring structure, this perspective places value on meaning and process in capturing the world of those who are being studied (Maines, 1977). In other words, interactionists consider that it is the patterns of action and interaction that make up groups and societies (Blumer, 1969; Ritzer, 2008) and thus the focus is on "how people produce their situated versions of society …" (Denzin, 1992, p. 23). Meanings are therefore not static and appreciation or meaning is constructed by the individual through their experiences, rather than being readily available to be discovered (Merriam, 1998). Meaning making is a social process (Denzin, 1992) and the emphasis is on how one interprets circumstances and chooses one course of action over another. Thus symbolic interactionism has been characterised as a theory with an emphasis on a person's capacity for change and social influence (Foote, 2004). According to Forte (2004), symbolic interactionism can help health workers understand culturally different interpretations of similar social experiences and explore meanings such as those of the members of undervalued groups.

The theoretical framework of symbolic interactionism is employed in this research because its focus is on the ways in which the experiences of study

participants of the role of the hospital employed nurse educator are shaped through interactions and within context in the workplace. The theoretical tenet of generation of meaning and its interpretation supports research such as this that addresses human interactions within a specific professional context (Blumer, 1969). As human behaviour responds to events and situations (Berg, 2004, 2007), the use of symbolic interactionism assisted the researcher in establishing social meanings associated with nurse educators and also contributed to the discovery and appreciation of patterned meanings and behaviours within and between the research participant groups.

3.1.1.2 Pragmatism and Symbolic Interactionism

It is generally acknowledged that symbolic interactionism has its origins in pragmatic philosophies spelled out in different ways by the founders of philosophical pragmatism: Peirce (1839-1914), James (1842-1910) and Dewey (1859-1952) and the pragmatic social psychologists Cooley (1964) and Mead (1934). In 1878, Peirce first introduced the term "pragmatism" as the name of a logical method for focusing on consequences of action (Peirce, 1955). According to James (1955), pragmatism is a method to make sense of everyday experiences, facts and data. As such, pragmatism refers to theoretical perspectives about how living things make practical adjustments to their surroundings (Reynolds, 2003). A general pragmatic proposition shared by advocates of pragmatism is that knowledge is inherent in human actions (Barbalet, 2009).

For Peirce (1966a, 1966b), knowledge does not represent reality but is a mechanism for dealing with it and as such is modified in light of new discoveries relative to time and place. In so arguing, pragmatists maintained that all understandings of reality were distorted through language and individual perceptual frameworks and hence all claims to knowledge are temporary. Thus knowledge development is not value free and is historically contextualised (Wuest, 2012). Differences in viewpoints are valued and offer a basis for shared problem-solving drawing on existing knowledge and resources and ongoing reconsiderations of understanding (Wuest, 2012). This means that knowledge of the self and the external world cannot be just given and thus cannot be the passive outcome of past experience but must be built on ongoing experience projected into the future as that is where the consequences of the current action are found (Barbalet, 2009).

The consequence of actions in the future, according to James (1955), means that uncertainty is constant in social experience. Thus for James (1955), the human organism is not just a product of external forces but one that has interests and is active in achieving and creating its own conditions out of adaptive necessity. The importance of the means of action rather than its environmental drive is also stressed by Dewey in another foundational statement of pragmatism (Dewey 1896). Thus, from a pragmatist perspective, humans can only be understood through what they do and inquiry should be directed at that which makes a practical difference in the real world of human action (Dewey, 1896). Here pragmatism, in grasping or developing a meaning of action, is concerned primarily with its consequences or outcomes (Barbalet, 2009).

Hence the interactionists accepted the pragmatic view that the world is not fundamentally limited but open to multiple determinations. This then led to a perception of society as a pluralistic universe continuously produced by the collective efforts of individuals (Shalin, 1991). Mead's (1934) work, with its emphasis on cognition and symbol at the expense of emotion, has had significant implications for the development of symbolic interactionism.

3.1.1.3 Symbolic Interactionism - Mead

An appreciation of Mead's (1934) assumptions assists in understanding the general positioning of symbolic interactionism. Mead (1934) assumed that humans are active and creative beings that influence the world they live in, and that, in turn, shapes their behaviours. Mead (1934) also considered that for a human, truth exists whereby one learns and remembers what is useful to one. Additionally, humans see and define objects in our environment according to their usefulness (Charon, 2007, p.32). Hence meaning attributed to objects lies in the effect they produce. Mead (1934) also purported that action and interaction should be the focus when studying social phenomenon rather than exclusively a person or a society.

As an extension of the above, Mead (1934) contended that a person's sense of self is significantly formed through the internalisation of the norms and values of the different groups to which they belong. As a result, these group standards are internalised and not simply learned but adopted and amalgamated into the person's

sense of self (Manning & Smith, 2010; Mead, 1934). That is, while an outsider might have an understanding of a particular event, only group members will feel similar emotional and visceral reactions that are concurrently the property of a person and the group (Manning & Smith, 2010). Thus, Mead (1936) argued that a person's self emerges during social experience and through activity within groups which results in socialisation and internalistion of group standards. Thus one learns to understand the different roles played by members of a group.

Mead (1936) also argued that since one qualifies for membership of different groups, one must have multiple personalities that are adopted because we internalise the requirements of each group and this leads to a sense of belonging. To conceptualise the process of forming a 'normal' multiple personality, Mead (1936) introduced the distinction between the 'I' and 'me'. The 'me' symbolises the attitudes of the group (e.g. community, organisation) and relates to sets of attitudes of others which one internalises and assumes (Mead, 1936).

Mead (1936) considered that an 'I' exists in each person (the response to attitudes to others). The 'I', according to Lewis (1979), is the response made by a person to the standards of the generalised other. Mead (1934) also postulated that it is the conversations between the 'I and 'me' that form the self. Thus awareness of the roles of others is essential in the development of self. As Mead (1936) noted, the complicated interplay between 'I' and 'me' leads to the conceptualisation of identity. In other words, individuals take the attitudes of others towards them, in response to their own attitudes towards them (Mead, 1934). This means that one is aware of oneself and of a situation, but how one acts does not come into one's experience until after action has occurred (Mead, 1934).

Self and society are then only considered possible because of communication which requires one to see things from the perspective of not only one's self but others (Mead, 1934). Hence, individuals are considered to act with each other and take account of themselves and others as they act to symbolically communicate and interpret each other's actions and behaviours (Charon, 2007; Mead, 1934). Mead (1936) indicates that people are not just products of society but are conscious

choosing individuals who construct their own social realities while living in the inter-subjective world of everyday life.

The perspective of Mead and symbolic interactionism is useful in gaining an understanding of the role of the nurse educator in providing insight into the ways in which individuals attach meaning to and shape their behaviour in groups by connecting with the self and to different group structures. The experience of the research participants of the role of the hospital employed nurse educator is characterised by interaction, subjective meaning, group membership and the role within the workplace.

3.1.1.4 Symbolic Interactionism - Blumer

Blumer (1969, p. 72) reiterated Mead's view that a sole focus on the individual was theoretically reductionist and subjective. Similarly, Blumer considered research restricted to social structure must invariably be subjective because it demands that the researcher impose predetermined definitions of reality onto the social world (Blumer, 1969, p.75).

Thus and in further extending Mead's work, Blumer (1969) proposed three premises for understanding individual/social relationships the first of which was that peoples' interactions with things, whether physical objects, stimuli, other people, social institutions, activities and/or situations, are based on the meanings that they have for those things. This in turn determines the way a person interprets something, the way they act towards it and the way they are prepared to talk about that something (Blumer, 1969; 1998).

The second premise articulated by Blumer (1969) concerns the source of meaning whereby meaning arises from a process of interaction that encompasses communication and broad understanding. As interaction continues, the meaning may or may not remain constant, as the meaning derives from a person's response to the responses of other people to the person or thing (Blumer, 1969). Consequently, work groups create their own culture through meanings attached to rituals that define their work role and attitudes towards work and towards others. Therefore, the

responses of the participants in the current research were influenced by their perceptions of the likely responses of their respective work group.

Blumer's (1969) third premise was that a person's developed meanings are continually tested and modified through an interpretive process used by the person in interactions with external phenomena. Hence, symbolic interactionism acknowledges ongoing interaction within groups of individuals in organisations and consequent modification of individual actions (Blumer, 1998).

From the above we understand that meaning is central to symbolic interactionism and as Blumer (1969) insisted, that the behaviour being studied is seen as falsified if the meaning of things toward which people act is ignored. Blumer (1998) proposed that actions are defined and redefined by an interpretive process that takes place through ongoing interaction between self and others. Consequently, when individuals associate with each other they are involved in interpretive interaction (Blumer, 1969). These central tenets are reflected in Denzin's (1989) work that outlined three fundamental assumptions linked to symbolic interactionism: individuals define their own situations; individuals are capable of self-reflection while at the same time directing their behaviour and that of others; and, in directing their own behaviours individuals can interact with others and adjust their behaviour as necessary. Blumer (1986, p. 60) argued that the researcher must 'respect the nature of the empirical world'. Denzin (1989) supports Blumer's (1969) perspective in also asserting that the researcher must enter the participant's world of social interaction to fully allow understanding of the participant's perspective of the situation being studied. Thus how the researcher constructs an account of a group's life is through the layered meanings applied to objects without initially knowing what these objects are, or even how many objects exist (Manning & Smith, 2010).

In the present study it was necessary that the researcher engage with the meanings of the worlds of the study participants. This approach allowed the researcher to determine meanings attributed to the role of the hospital employed nurse educator within the context of the workplace according to understandings attributed by different groups.

3.1.1.5 Symbolic Interactionism - Goffman

Between the early 1950s and the early 1980s, Goffman undertook work that focused on the organisation of observable, everyday behaviour in a range of settings leading to the development of concepts and classifications to describe and analyse different social interactions. Goffman (1963) contested that any face to face interaction requires that those participating need to be able to sense that others are close enough to them to be able to register whatever it is that they are doing. In asserting this view, Goffman (1963, pp. 13-22) identified three types of co-presence; the 'gathering', the 'situation' and the 'social occasion'. Goffman (1963, p. 24) explained these types of co-presence as gathering to be the coming together of two or more people, a situation occurring whenever there is mutual observation and a social occasion as an entity that brings a group of people together for a particular occasion at a particular time. Goffman (1963) argued that for each of these there are distinct patterns of communication which are regulated by an evident ethical code. Each form of interaction is thus focused and involves specialised communication and a degree of mutual activity that is most likely to be seen among those who know each other (e.g. friends, acquaintances) (Goffman, 1963, p.24).

Unfocused interaction is considered to occur where people are unacquainted with each other and in this situation the flow of information occurs initially through body language (Goffman, 1963, pp. 13-14). According to Goffman (1963), the attention that one gives to others in social situations through observable symbols relates to our degree of involvement and thus assists one to manage and appear normal in given social situations. Thus, while personal identity is unique, one's social identity is what others understand about us by virtue of the groups to which we belong. In posing these views Goffman (1963) also suggested that, when there is interaction between roles that is more of a matter of difference, stigma may occur and contested that we are all stigmatized in some situations and at some point is our lives if one does not appear normal in given social situation. According to Goffman (1963), stigma is not about a person and the attributes they, or a group, possess but about the relations of the roles played.

Goffman (1969) argued that since most people are skilled in managing the impressions they give, they monitor aspects of the conduct of others and the impressions they give and in thus doing so each actor seeks to deceive others while

at the same time seeing through the misleading practices of others. That is, a person claims a certain social value through their approach to an encounter, and the view of self and others expressed through verbal and non-verbal acts. Goffman (1969) offers the premise that one presents a front in all behaviour before others. Additionally, certain behaviours may be considered appropriate in certain circumstances and that some form of convention is inbuilt in actions. In this research, Goffman's (1969) categorisations and conclusions are useful as they prompt consideration of the importance of separation of events that shape participant actions and interactions within the social setting of the workplace.

3.1.1.6 Symbolic Interactionism – Key Concepts

Symbolic interactionism thus assumes that human nature is not motivated solely by external, or internal, factors but rather through meaningful reflexive interactions between individuals (Farganis, 2011). Social interaction is achieved through symbols, with language being the most significant symbolic system as it is a key in expressing social life. Individuals therefore learn the meanings of objects in life through socialisation and interactions in which meanings are developed and refined. As a result, some meanings will be learnt differently by different groups at varying times and places (Blumer, 1969; Mead, 1936; Ritzer, 2008). Therefore, in exploring the social interactions of nurse educators, throughout the research ongoing consideration was given to relevant symbols, including language and behaviours that exist in a continuous 'state of flux', and were constantly changing through interaction (Blumer, 1969; Denzin, 1989; Denzin & Lincoln, 2005).

Although the focus of the present research was to advance knowledge by interpreting the phenomena of the world of the nurse educator, social interaction within the acute healthcare setting also needed to be explored in light of its potential to influence outcomes. No matter what roles people assume, they will shape who they are and how they interact in their social worlds with 'self' defined by the social role in which one is involved (Annells, 1996; Mead, 1934). Additionally, persons who share common circumstances, for whatever reasons, tend to share common meanings and subsequent inter-subjective behaviours and activities (Patton, 2002; Mead, 1934).

Symbolic interactionism as the theoretical underpinning of this research brought focus to the social acts, both individual and collective, of the participants and the associated meanings so that patterned social processes could be discovered and understood (Blumer, 1969). It required an emphasis on the meanings given to phenomena and the continuous and systematic reinterpretation of those meanings within a social context (Milliken & Schreiber, 2001). This view is important as it is argued that nurses collectively and nurse educators as a subgroup, share behaviours consistent with a concept of 'joint action' whereby an individual does not develop in isolation, but the self emerges from the responses of others and from the way they respond to and develop their own responses to others (Blumer, 1998; Goffman, 1963; Mead, 1936).

Symbolic interactionism supports the perspective that the individual is capable of membership of multiple groups simultaneously and relates to different generalised others at different times (Mead, 1934). Each participant is an actor who constructs the meaning of their experiences and then acts on the basis of that meaning (Mead, 1934). More importantly, an individual identifies one's self with the meanings experienced by a group or the larger community (Mead, 1934).

In considering this perspective, the researcher also reflected on Blumer's (1969) caution that failure to recognise that 'joint action' provides stability and predictability to social interaction is a mistake. In light of this caution, the researcher ensured that participant meanings were documented and interpreted, rather than those of the researcher (Denzin, 1989; Denzin & Lincoln, 2005). This was achieved by documenting verbatim the words of each participant, paraphrasing participant statements, clarifying behaviours and expressed language. Additionally, the common set of symbols and understandings between the study groups and individuals were ascertained and the participant data guided analysis. Additionally the researcher, as much as possible, attempted to understand the perspective of the participants (actors) as well as those of the groups to which they belonged. Consequently, the researcher paid attention to the concept of the emergence of self during social interaction with groups and attempted to understand the different roles played by members of a group, their sense of belonging and how they attached meanings that shaped behaviours. The researcher also considered that the research

participants were conscious choosing individuals who were active in constructing their social realities while living in the world of everyday life. As such, it was acknowledged that their socially constructed reality was subject to change and dependent on roles played, experiences, and one's sense of identity and belonging.

Additionally, the researcher considered context in taking into account social structures such as power, organisation, culture and practice. Blumer (1969) argued that human behaviours occur within social and cultural constraints and as such affect how individuals define a situation, develop their understandings of these structures and their respective interactions. Thus one adopts the perspective that best fits how one defines themself in a given situation and attempts to try and understand the world view of others in order to define the situation and establish how to behave (Charon, 2007). This process of reflection is about accommodating change and maintaining stability and leads to negotiation between groups and individuals with the aim of achieving shared meaning and perspectives of the social world (Dennis & Martin, 2007). It also assists an individual to gain a view of how they appear and are judged by others and to then act in ways consistent with imagined expectations (Dennis & Martin, 2007). Hence, in line with the pragmatic view, the symbolic interactionist perspective asserts that "meaning is not fixed and immutable; rather it is always shifting, emergent and ultimately ambiguous" (Plummer, 2000, p. 194). Hence, the structural conditions in providing the social context for interaction are considered in this research as it is acknowledged that context and social structures, combined with meaning construction and definition, shaped the actions, interactions and experiences of the participants.

Symbolic interactionism was chosen as the theoretical framework underpinning this study because of its focus on understanding how participant behaviours have been shaped through social interaction and interpretations in a particular context (Blumer, 1969; Goffman, 1963; Mead, 1934; Milliken & Schreiber, 2001). This theoretical view provided the lens through which participant interpretations and constructions of experiences of hospital employed nurse educators could be explored. The research also considered how social structures (such as power, organisation, culture, emotions) shaped individual behaviours. The combination of constructed experiences and social structures locates the study theoretically.

3.2 Research Methods

Berg (2004, 2007) asserts that the principal purpose of research is to ascertain answers to questions. The nature of the answers will indicate the questions to be asked and will influence the selection of either quantitative or qualitative methodology. As was argued above, it is important to be epistemologically consistent and clear about the theoretical framework of a research activity (Crotty, 1998). Consideration of a research methodology that would provide a fit with the research question posed by the researcher led to the adoption of an interpretive approach with the underpinnings drawn from symbolic interactionism (Annells, 1996, 1997; Blumer, 1969, 1998).

Grounded theory is a largely inductive method, which means that theory is derived from the data, whereby theory is likely to be better able to predict and explain, and be relevant (Glaser & Strauss, 1967). Grounded theory also includes discovery, as it enables the researcher to find out about other peoples' 'realities' (views of the world), recognising that they are constructed realities because of the emphasis on comprehending the study participants' viewpoints for interaction, process and social change (Strauss, 1987). This theory-discovery method assists the researcher to develop a speculative account of the general features of a topic, from-the-ground-up while simultaneously grounding the interpretation in empirical observations or data that facilitates an understanding of the complexity of the topic under study (Merriam, 1998).

In this research, the researcher sought to discover knowledge and comprehend behaviour and meanings as they are understood by participants. Therefore, grounded theory was considered appropriate because of its ability to generate theory regarding patterns of behaviour within a substantive setting especially as there is little existing formal knowledge of the research topic, particularly in the Australian context.

3.2.1 Grounded Theory Research Method

Grounded theory is compatible with the theoretical perspective of symbolic interactionism in the sense that this method encourages the determination of research outcomes that explain the meaning of complex social interactions and it facilitates

understanding of socially constructed meaning from the perspective of a given time and context (Annells, 1997; Chenitz & Swanson, 1986; Corbin & Strauss, 2008; Martin & Turner, 1986). Grounded theory was originally developed by Glaser and Strauss (1967) who proposed that the method inductively constructed theory from data generated through the study of the phenomenon it represents. Subsequent works in this area have retreated from the claim of a purely inductive approach (Corbin & Strauss, 2008; Charmaz 2000, 2006; Straus & Corbin, 1998). Nonetheless what has endured is the argument that grounded theory data analysis is undertaken concurrently with data collection, the major intent of which is to develop theory that explains human behaviour (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Fundamentally, the method, with its inductive and deductive components, is used to generate new theory and understanding rather than test existing theory (Sandelowski, 1986; Streubert & Caprtenter, 2011).

The value of grounded theory is in its capacity to develop a speculative account of the general features of a topic and to construct theoretical conceptualisations by integrating concepts to identify relationships through an understanding of the complexity of human behaviour and social interaction (Corbin & Strauss, 2008; Glaser, 1998; Strauss & Corbin, 1998). This being the case, this method seeks to derive meaning situated in the socio-social dimensions of the human interactive experiences and to construct theory about issues of importance in peoples' lives (Glaser, 1998; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Issues of importance to participants are grounded in the stories they relate about an area of interest that they have in common with the researcher.

Data analysis occurs through constant comparison, initially of data with data, progressing to comparisons between researcher interpretations translated into codes and categories and to more data (Morse, 2001). The researcher who brings an understanding to a situation interprets participant generated data to construct a theory (Corbin & Strauss, 2008). In the present research, the methods of grounded theory facilitated insight into and interpretation of the complexity of the role and contribution of the public sector nurse educator as they relate to the continuing education needs of the nursing profession.

A divergence of views between Glaser and Strauss, over method and changing contexts of grounded theory, initially gave rise to parallel versions of the approach (Charmaz, 2000, 2006). However, over the past four decades grounded theory has undergone considerable evolution resulting in numerous approaches founded on different ontological foundations (Corbin & Strauss, 2008; Charmaz, 2000, 2006; Glaser 1992; Strauss & Corbin, 1990, 1998). Nonetheless and as Annels (1996) and Backman and Kyngas (1999) have argued, provided that the key principles of grounded theory are adhered to the researcher may adapt the method to suit their own research project as no research studies can be compared like for like. However, it is recommended that a researcher follows one coherent approach and maintains consistency in application to minimise potential confusion and findings lacking in substance (Backman & Kyngas, 1999).

The differing perspectives of the so-called Glaserian version, based on the writings by Glaser whose background was in quantitative research and the so-called Straussian version, propounded by Strauss and Corbin (1998), are outlined below.

3.2.1.1 Glaserian Version of Grounded Theory

Kendall (1999) suggested that the core of the issue of difference between Glaser and Strauss was the introduction by the latter of axial coding where the data are put back together in new ways by making connections between categories. Strauss and Corbin (1998) set down the conditions whereby connections might be made and this was a direct challenge to Glaser's insistence that grounded theory was an inductive method. Glaser's (1992) strongest criticism has therefore predictably been directed to axial coding which he perceived was a "forced analysis of data through preconceptions, analytical questions and hypothesised methodical techniques rather than permitting the data to take its own form" and allowing categories to emerge through comparison of data against data (Glaser, 1992, p.5). In response, Glaser (1992) argued that the purpose of grounded theory was theory generation and not the theory verification that appeared to be the main focus of the Strauss and Corbin perspective.

3.2.1.2 Straussian Grounded Theory

Strauss and Corbin (1998, p.11) were consistent with Glaser's view that grounded theory was appropriate when studying problems focused on "research about person's lives, lived experiences, behaviours, emotions and feelings as well about organisational functioning, social movements, cultural phenomena and interactions between nations". Yet, these authors maintained that their process allows the researcher to be guided by a more complex, systematic and accurate method than the Glaserian version through the application of more analytic methodological tools. Notably, Corbin and Strauss (2008, pp.6-8), unlike Glaser, have also acknowledged pragmatism and symbolic interactionism as the philosophies that underpin their iteration of grounded theory methods. Corbin (Corbin & Strauss, 2008, p. 10) refers to coming to the realisation that there is no 'one reality' waiting to be discovered and that each person "experiences give meaning" to occurrences according to their own experiences. As such, Strauss and Corbin (1998) challenged Glaser's concept of 'emergent theory' in arguing that there is no pre-existing reality to be revealed. Rather the researcher brings a range of resources to data interpretation and as such is actively involved in constructing theory. Hence, this approach was more likely to engender insight, understanding, and a meaningful guide to action as participant assumptions and shared understandings about the role and contribution of the hospital employed nurse educators are the research intent.

The Strauss and (refined) Corbin approach (Corbin & Strauss, 2008; Strauss & Corbin, 1998) offers the researcher a framework that assigns a focus on conditions, actions/interactions and consequences. However, while Strauss and Corbin (1998) describe three levels of coding process (open, axial and selective), these do not occur as separate entities occurring as a linear formation. The levels are strongly linked and application of the constant comparative method requires the researcher to continuously compare data with all other data at every level of analysis (Schreiber & Stern, 2001).

To assist in capturing the conditions in which events are found, Corbin and Strauss (2008, p. 90) suggested that the researcher acknowledge that conditions/consequences do not exist in a vacuum but rather are interconnected through actions/interactions/emotional responses. This means that one event leads

to another where relationships formed are often complex and do not follow a linear course (Corbin & Strauss, 2008). As such, they are difficult to determine, as they tend to recoil off each other, leading to unpredictable consequences (Corbin & Strauss, 2008). Contextual conditions often occur in clusters and can co-vary (that is, one condition changes with changes in another) in different ways and over time and as a result of contingencies can rearrange themselves such that relationships and interactions change (Strauss & Corbin, 1998). Analytical depiction is one form of connectivity with discernible shifting in patterns of action/interaction over time (Corbin & Strauss, 2008).

Context and process are linked as people act in response to something (e.g. issues, problems, situations, goals and events) occurring in their lives. Corbin and Strauss (2008) opined that the relationship between context and process is very complex, resulting in variation in the intensity, type and timing of responses. As the contextual conditions change, variations in action/interaction and emotional responses also occur, with the extent of response dependent upon the meanings given to the situations (Corbin & Strauss, 2008). This results in individual variation in connection between context and relationships, causing shifts in the patterns of interaction over time (Corbin & Strauss, 2008).

The grounded theory frame provides detailed and systematic procedures for data collection, analysis and theorising, but is also concerned with the quality of generated theory. Strauss and Corbin (1990, p. 23) identified that a well-constructed grounded theory should:

- fit the phenomenon, provided it has been conscientiously drawn from diverse data and adheres to the everyday reality of the topic;
- provide appreciation, and be understandable to the persons studied;
- have generality, in that data are comprehensive and interpretations broad so the theory is abstract enough to be relevant to a variety of contexts;
- have conceptual density which provides direction, in the sense of stating the conditions under which the theory applies and describing a realistic basis for action.

Within this frame there are unique characteristics designed to maintain the 'groundedness' of the approach. Data collection, which can be drawn from many sources, and analysis are consciously combined and initial data analysis is interpreted, validated and used to shape continuing data collection (Bulmer, 1969; Corbin & Strauss, 2008; Glaser & Strauss, 1967). Strauss and Corbin (1998) recognised the place of personal experience, professional background and perceived need as well as offering the option of undertaking a literature review at the commencement of the study to inform the area of study, in contrast to Glaser (1998), who strongly argued for an open approach. Recognition of background experience and an initial literature review facilitates researcher contemplation of the particular context within which the participants act and the influence that this context has on their actions (Corbin & Strauss, 2008).

Although Glaser's (1998) approach predicates that there should not be a pre-conceived theory in the mind of the researcher this is not the case in the present research as existing knowledge has influenced the researcher (Forster, 2005; Queensland Health, 2007b, 2010a). Thus the emphasis on building, rather than testing, preconceived theories does not mean the researcher did not bring pre-determined assumptions to the research. Indeed, as the study progressed the processes moved from inductive to deductive, with initial ideas used to test against new data (Strauss & Corbin, 1998). Consequently theoretical understanding that offered an explanation of phenomena rather than just a set of findings was generated (Strauss & Corbin, 1998).

The aim of the present research was to generate theoretical understandings that are relevant to the contextual boundaries of the hospital employed nurse educator. An overview of the process used by the researcher is provided in Table 3.1.

Table 3.1: Grounded Theory Process

STAGE		*ACTIVITY*	*RATIONALE*
RESEARCH DESIGN STAGE			
Step 1	***Provisional Review of literature***	Definition of provisional research question Possibly a priori constructed	Assisted in focusing effort /organization. Provided an initial guide to direction and identifies gaps. Provided guidance in substation of purpose & what findings may add. Offered a better grounding of construct measures Constrained irrelevant variation and supported verifications
Step 2	***Selection of participants***	Provided a purposeful, not random selection	Focused efforts on purposeful situations/participants / homogeneous sample / Interviews Facilitated understanding (e.g. assists in developing and/or extending theory)
DATA COLLECTION STAGE			
Step 3	***Development of rigorous data collection protocol***	Created interview database Exploration & employment of data collection methods as relevant Demographic data collected as relevant	Managed data & contributes to integrity of data collected Strengthened grounding of theory with available evidence. Enhanced internal validity Provided a synergistic view of evidence and context
Step 4	***Entering fields***	Overlap of data collection and analysis Considered flexible and opportunistic data collection methods as relevant. Referred to other sources and extant literature.	Enhanced analysis and iterative process and reveals helpful adjustments to data collection Provided the researcher the opportunity to take advantage of emergent themes and unique features of the data / research and sources
DATA ORDERING STAGE			
Step 5	***Data ordering***	Arrangement of actions chronologically	Facilitated data analysis. Supported in depth examination and re-examination of processes

STAGE		*ACTIVITY*	*RATIONALE*
DATA ANALYSIS STAGE			
Step 6	***Analysing data***	Use of open coding Use of axial coding Use of selective coding	Developed concepts, categories, theoretical construct Developed connections between a category and its sub-categories Incorporated categories to build theoretical framework All forms of coding augmented to ascertain internal validity
Step 7	***Theoretical sampling***	Factual and theoretical replication – applying step 2 - until no new information was generated	Focuses data collection. Confirms, extends, & hones theoretical framework
Step 8	***Reaching closure***	Possible when no new information is generated.	Process is complete when new data progress becomes minor &/ or new information generated.
LITERATURE COMPARISON STAGE			
Step 9	***Compare emergent* theory *with existing literature***	Facilitated comparisons with any conflicting & or similar frameworks	Improved construct definitions, & therefore interpretative rigour Improved rigour through determining the domain to which the research's findings were generalised.

(Strauss & Corbin, 1998)

3.2.2 Overview of Strategies

This research initially used purposive sampling and progressed to theoretical sampling, as suggested by Corbin and Strauss (2008) and Glaser (1998). Purposive sampling (a non-random method of sampling) was used as this approach provided the researcher with a sample whereby a richness of data surrounding issues of fundamental importance to the purpose of the research could be collected (Coyne, 1997). Essentially a combination of criterion and homogenous sampling was undertaken, as each of the four sample groups was chosen based on the understanding of the needs and knowledge of the members of each group, relevant to role of the nurse educator in their natural work setting. Data collection and analysis from each of the four sample groups directed further choices and the progression to theoretical sampling (Cutcliffe, 2000).

Table 3.2 provides an overview of the research design applied to this research.

Table 3.2: Overview of Research Design

Research Methods	
Participants	• Purposeful selection x 4 homogenous groups • Theoretical sampling for in-depth semi-structured interviews • Researcher considerations
Data Gathering Strategies	• Documentation review • Demographic Survey • In-depth semi-structured Interviews
Analysis of Data (occurred simultaneously with data gathering)	• Document analysis • Constant comparison of data • Concept / Category / Theoretical Construct utilising NVivo as data management tool • Descriptive analysis of Demographic Data
Interpretative Rigour	• Evaluation quality criteria • Balance between rigour and creativity • Researcher activities

(Corbin & Strauss, 2008)

3.3 Research Participants

Consideration of the wide geographical distribution of nurse educators working in Australia led to a pragmatic decision to enhance workability by focusing the research on a Queensland geographic context. Recruitment centered on nurse educators who worked in one of the three designated area health services that comprised the Queensland Health infrastructure. The area health service comprised eight Health Service Districts encompassing a total of forty-nine health care facilities. The total number of nursing personnel in each Health Service District was over one thousand. Fifty-five (55) participants were drawn from metropolitan, provincial and rural facilities ranging in size from 30 to 985 beds. Based on generic award statements (Queensland Health, 2008a), the nurse educator role and its contribution to continuing professional development were similar in each of these three contexts in terms of approximate customer numbers, demand and application of nurse educator services.

An overview of the participant group participant numbers, location and gender is provided in Table 3.3.

Table 3.3: Research Group Demographics

			Gender		Location		
Group	**Number**	**Percentage**	**M**	**F**	**Metro**	**Prov**	**Rural**
Line Managers (Nursing Directors, DDON's)	13	24%		13	6	3	4
NUM'S	11	20%	1	10	8	2	1
Nurse Educators	21	38%	1	20	8	8	5
Clinical Nurses	10	18%		10	7	1	2
			2	***53***	***29***	***14***	***12***
Total	**55**						

Legend Used in Table

Metro = Metropolitan
LM = Line Managers
DDON = District Directors of Nursing
DON = Directors of Nursing
NUM = Nurse Unit Managers
NE = Nurse Educator
CN = Clinical Nurse

Prov = Provincial
Gen = Gender
F = Female
M = Male

3.3.1 Selection, Preparation and Organisation of Participants

Following a review of existing Queensland Health models of nursing continuing professional and staff development education, nurse educator job descriptions, generic statements (Queensland Health, 2008a), plus researcher-supervisor discussions, the decision was made to focus on four homogenous groups in the research.

Registered nurses, who constituted the purposeful sample (Nurse Educators, Line Managers, Nurse Unit Managers and Clinical Nurses), were invited to participate in the research by letter (Appendix 1). The invitation outlined the purpose of the research and the criteria for participation in the research and explained the research design and data collection methods. The length of the research, steps taken to ensure confidentiality, expectations of the research and communication of findings were explained to the participants, the hospital administrators, the university and the wider community. These groups were chosen either because of the relevance of their role to the research intent or because of the

extent of their interaction with nurse educators and/or their potential to influence nurse educator interaction and outcomes (Silverman, 2005 pp. 130-131).

Morse (2000) suggested that the sample size considered necessary to provide rich data for qualitative studies depends on the scope, nature and design of the research plus the quality of the data. The four homogenous groups comprised Nurse Educators, Nurse Educator Line Managers, Nurse Unit Managers and Clinical Nurses employed by Queensland Health. Data were collected from each of the four groups non-sequentially to accommodate participant availability and facilitate analysis.

The criterion for inclusion for each group was based on classification of employment for each of the four sample groups of registered nurses employed in the Queensland Health Area Health Service. No healthcare facility was excluded from the research because of clinical service capabilities, as provisional discussions and documentation review determined that service capability should not impact on research intent to explore the role and contribution of the public sector employed nurse educator across Queensland. Participants were recruited across the Area Health Service via Directors of Nursing and Midwifery, nursing education networks and facility meetings. Every participant who volunteered for the research was provided with a Participant Information Sheet (Appendix 1) and explanation, in order to allow informed consent (Appendix 2). Before individual interviews, the participants were advised they were able to voluntarily withdraw at any time during the research period without any penalty or adverse effect for them personally or in terms of the role in which they were employed. Participants were also informed that in the event of their withdrawal, any information provided by them would be destroyed. All participants signed a consent form (Appendix 2). No participant withdrew from the research. Demographic information from research participants (Appendix 3) was collected in an anonymous form to provide data regarding participant classifications, employment locations, gender, and education status to be used in the analysis if deemed significant. Descriptions of scopes of practice of participant groups are provided below.

3.3.1.1 Group 1: Nurse Educators

Nurse educators are the only nurses who have experience of enacting the nurse educator role and contribution; consequently they were central to the research aims. To minimise undue influence, no nurse educator with a direct line of report to the researcher was included in the research. The total sample size of this group was twenty-one (21) participants.

3.3.1.2 Group 2: Line Managers

Line managers (of the nurse educators) comprised Health Service District facility nursing executives, as these positions from District Directors of Nursing (in rural Health Service Districts), Nursing Directors (Clinical Service Lines in some provincial and metropolitan Health Service Districts) and Nursing Directors, Education (in some provincial and metropolitan Health Service Districts). These thirteen (13) participants were responsible for providing direction, leadership and support to nurse educators.

3.3.1.3 Group 3: Nurse Unit Managers

Nurse Unit Managers fulfill the role of management of clinical work units and thus authorisation of support for clinical staff participation in nursing education activities. This group was chosen because the members oversee fiscal and resource responsibility for rostering or releasing staff from clinical work to participate in mandatory training, continuing professional development and other knowledge translation activities. The total sample size of this group was eleven (11) participants.

3.3.1.4 Group 4: Clinical Nurses

Clinical nurses were a group of ten (10) consumers of nurse educator services. This classification was chosen because it constituted advanced clinical specialty roles in work units wherein the participants had knowledge of and potentially a high degree of interaction with nurse educators in the workplace.

3.3.2 Participant Identification

Codes were applied to the data to allow identification of data sources while ensuring confidentiality. In order to track data to the original source, names were replaced by codes, with the classification level and data source maintained. A confidential list of original participant names with aligned codes was secured by the researcher for cross-checking purposes only. Interview and demographic codes were allocated in a non-sequential manner to further support confidentiality.

3.3.2.1 In-depth Interview Group, Gender and Participant Codes

Identification codes and numbers were provided, and the line or lines of transcribed interview were identified. The in-depth interviews were coded by identification (IDI), participant group, gender and the number of the interview. Each participant group was coded according to group classification: Line Manager "LM", Nurse Educator "NE", Nurse Unit Manager "NUM" and Clinical Nurse "CN". The identification IDI and group are followed by a designated gender code ("1" indicates female; "2" indicates male), and the participant's in-depth interview number is provided in the bracket. For example, IDI "LM 1 (8)" indicates the participant is a female line manager with interview number eight. The line of the transcribed text completes the code; for example, IDI "LM 1 (8) L80", where the respective content is at line 80 of the transcription.

3.3.3 Sample Size and Sampling Techniques

Sample size was not predetermined before the research commenced. Rather, sampling decisions evolved during the research process (Corbin & Strauss, 2008; Strauss & Corbin, 1990). A key component of grounded theory is to generate sufficient in-depth data to illuminate patterns and perceptions of the phenomena of interest (Strauss & Corbin, 1998). Consequently the researcher expanded the sample size until no new information was appearing in the data analysis process (Strauss & Corbin, 1998). As a result of this method, sample size varied across the four research groups.

Purposive sampling was initially undertaken in this research to recruit individuals with appropriate knowledge of the meaning, process, interpretation or theory, in order to describe and understand the phenomenon in question (Coyne, 1997; Rice & Ezzy, 2001). Purposive sampling is used in qualitative research to extend knowledge by deliberately selecting sample participants known to be rich data sources (Hancock & Algozzine, 2006; Patton, 1990, 2002; Luborsky & Rubinstein, 1995). Groups participating in the research were considered homogeneous (Richardson & Rabiee, 2001). The research was perceived to be suitable for purposive sampling at the outset and for progressing to theoretical sampling.

Theoretical sampling entailed the process of drawing concepts, conceptual ideas and categories from the data through the application of constant comparison. This process assisted to direct further data generation as theoretical sampling is not constrained to participant selection but also includes selection of incidents (Strauss & Corbin, 1978). Consideration of incidents facilitates the alteration of interview questions to address understandings and allows for interview question alteration (Strauss & Corbin, 1998). Alteration of interview questions was used to assist with theory development in this research. This design was relevant, as the purpose of theoretical sampling changed due to open, axial or selective coding (Strauss & Corbin, 1998). This strategy was supported by Morse (2000), who maintained that it is imperative to identify participants who have experienced and understood the relevance of the phenomenon under research, as was the case in the present research.

Even though, in grounded theory, researchers are unable to pre-determine the research sample size, Human Research Ethics Committees require that applications for ethics approval refer to a nominal sample size, irrespective of the research method. While some sample size guidelines were located for grounded theory studies the guidelines were inconsistent in recommending samples ranging from twenty to thirty (Morse, 1994; p. 225) and thirty to fifty (Creswell, 1998, p.64) participants. The researcher also appreciated that the idea of saturation is open to interpretation and criticism (Morse, 1994). After forty-three in-depth interviews a degree of theoretical sufficiency had been achieved with no new significant concepts appearing in any of the categories. However, as a point of saturation is always open

to interpretation and is quite provisional an additional three interviews were undertaken with each group to strengthen conceptual connections between categories, patterns, and perceptions gained from proceeding interviews. This resulted in a total of fifty-five in-depth interviews.

3.4 Data Collection

The theoretical and epistemological underpinnings of this research allowed the application of diverse methods for gathering rich data. The use of grounded theory was intended to facilitate identification of the main categories generated by the grouping and integration of coded concepts under a single cover term. Grounded theory is a repetitive process where the researcher was required to return constantly to data sources, to check aspects of the developing interpretation and to gather new data as and where appropriate. Smith and Biley (1997) refer to grounded theory as a process of constant comparative analysis. The main features of the area of interest are mapped through repeated comparison of data.

The following figure provides a basic representation of the data collection and analysis process undertaken in this research. It should be noted that although sampling, data collection and data analysis are identified separately, they are not distinct entities. Rather these processes occur both simultaneously and sequentially and thus have a reciprocal relationship with each other.

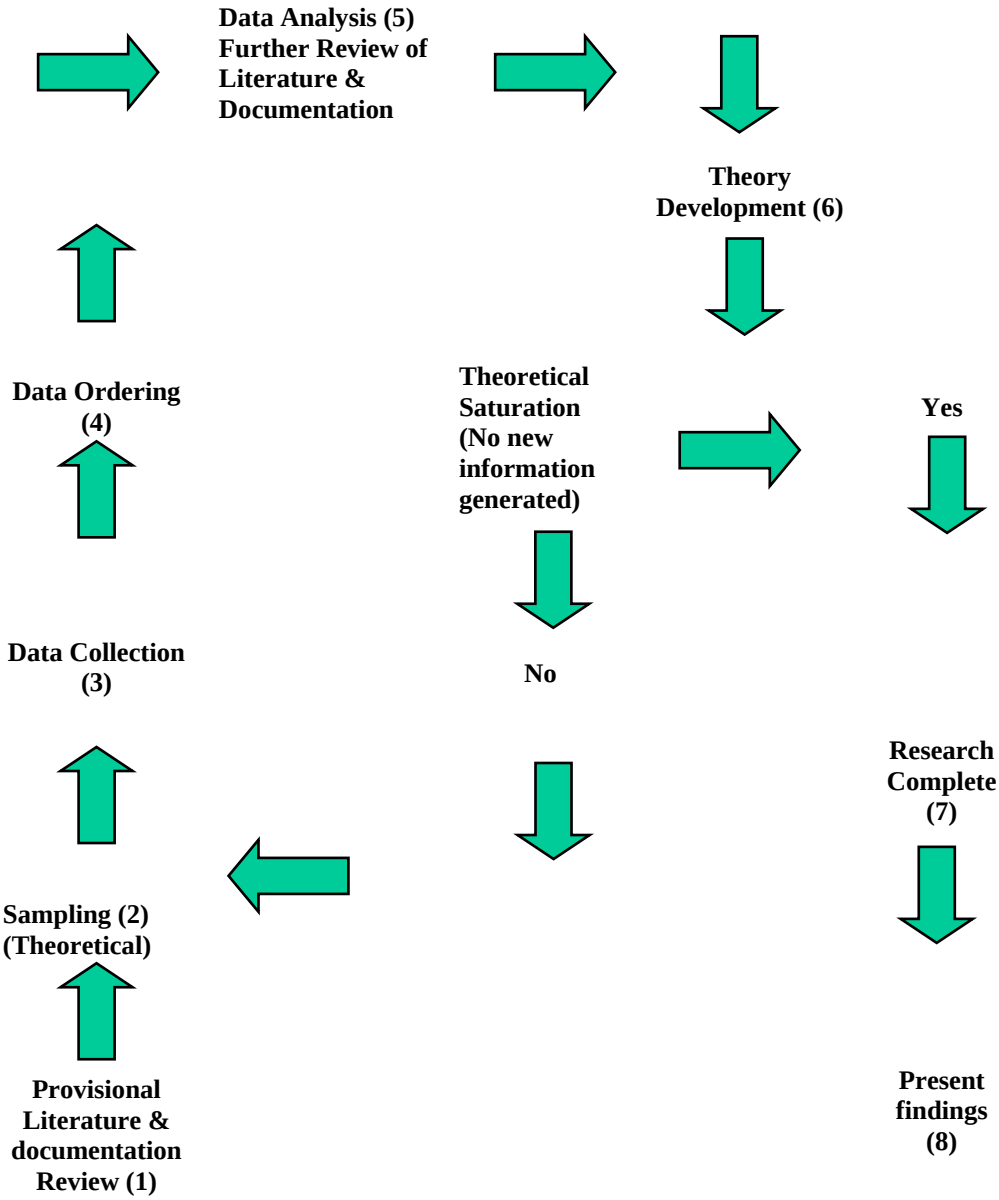


Figure 3.1: Adaption of Pandit (1996) Grounded Theory Interrelated Data Collection and Analysis

As directed by the research design, the evidence of this research was strengthened by data collection, while remaining sufficiently open and flexible to permit in-depth examination of the phenomenon. Data collection continued over a seven-month period until no new information was being generated (Corbin & Strauss, 2008; Patton, 2002). In keeping with the theoretical perspective of symbolic interactionism the data were explored and interpreted in respect to participant meaning and interpretation (Blumer, 1998). Data collection, coding and analysis were under taken simultaneously with new data, concepts, ideas and

suggestions constantly compared with previous data to generate the varying perceptions of the contribution of the public sector employed nurse educator to the continuing needs of the nursing profession (Corbin & Strauss, 2008; Patton, 2002; Richards, 2005). Grounded theory is not just findings and facts but is a generalisation as a result of things seen, experienced or believed combined into theory that is adjustable as new data originate from such sources as participants, extant literature and colleague comments (Corbin and Strauss, 2008).

3.4.1 Exploration of Documents

Documentation is a useful source of data as it is readily accessible, non-intrusive and does not alter research outcomes. It also provides direction and a checking mechanism for information obtained from surveys and interviews. Further it assists in collaborating and augmenting evidence from various sources and in identifying new 'real world' issues or questions about the phenomena, which can be treated as triggers for further investigation. However, documentation generated independently of the research is often fragmented and may not fit the conceptual framework (O'Donoghue, 2007). Documentation selected for this research was not produced specifically to address the research problem. Therefore, limitations regarding selectivity, incompleteness and quality variability were considered and addressed (Merriam, 1998; Patton, 2002). While the diversity of documents assisted in developing insights relevant to the research problem, these raw data needed to be transferred into a readable form for data analysis; relevant information was highlighted, categorised, coded and retyped into manageable data sets (O'Donoghue, 2007).

Document data collection for this research constituted national and statewide reviews of nursing, nursing education and the health sector; public sector, nursing awards; Queensland Health, Queensland Nursing Council and Queensland Nurses Union resources including reports, minutes and industrial relation manuals. As previously identified, consideration was given to the authenticity of the documents, the conditions under which they were produced and their contribution to the research purpose.

3.4.2 Demographic Data

Demographic data were collected via a survey (Appendix 3) from all fifty-five research participants. The primary focus was on socio-demographic data describing general characteristics of participants. Information sought included gender, age, classification, location, years in role and facility, awards gained or being studied. Demographic data were gathered at a different time from the interview to further minimise potential identification (Appendix 4). These data provided a contextual overview of the sample groups as they were sourced across rural, provincial and metropolitan sites. Not unexpectedly most participants were located in metropolitan or provincial facilities (Appendix 4). This was expected based on the variation in service capability of facilities (the designation of clinical services, according to the clinical roles and responsibilities of the different facilities) from which research participants were drawn.

3.4.3 Interviews

The prime source of data collection was the interview. Interviews are considered to have high 'face validity' due to the credibility of comments from participants (Barbour, 2005). In this research individual semi-structured interviews were used to facilitate the process of the researcher and the participants moving back and forth to interpret the present and envisage the future (Rubin & Rubin, 2012). Grounded theory requires a close interplay between sampling, data collection and data analysis that directs future sources for data (Backman & Kyngas, 1999).

The interviews were undertaken using a semi-structured technique. Initially each interview focused on five broad queries:

1. Tell me about a typical day of a nurse educator.
2. What do you believe is the appreciation that the majority of nursing staff would have regarding the elements of a nurse educator role?
3. What do you believe the evolving nature of the role should be?
4. What do you believe is the nature of the hospital-employed nurse educator's contribution to the continuing education needs of the nursing profession?
5. What processes are used to facilitate nurse educator contribution to continuing education and clinical practice?

These questions were formulated following review of the literature, discussions with the supervisors and through the researcher's knowledge and experience as an 'insider'. The questions were seen as providing the broad parameters for an interview that guided discussion towards issues important to the participant. The intent of using broad questions was to encourage participants to recount their stories and life experiences from their own perspective (Corbin & Strauss, 2008; Wimpenny & Gass, 2000). To facilitate access to relevant data, at the conclusion of the interview each participant was offered the opportunity to discuss additional aspects of the research important to them but not necessarily identified. A summary of the research design and its relationship to the provisional questions is provided in Appendix 5.

The majority of interviews were arranged at times to suit participants and their workloads and were conducted in the participant's workplaces as this is the 'natural setting' of the phenomenon being explored (Duffy, Ferguson, & Watson, 2004). Additionally, most interviews were undertaken in a suitably quiet, private environment (private office with teleconference facilities). However, due to geographic and cost considerations some interviews were conducted via telephone. While the researcher appreciates that face-to-face interviews have a propensity to provide greater non-verbal cues, the inclusion of data from provincial and rural health service districts was considered integral to the fabric of this research. Furthermore, preparation was undertaken prior to telephone interviews with the participant contacted the day before to cross-check availability and access to an appropriate environment. The researcher attempted to elicit information from telephone participants to a standard similar to that of face-to-face interviews and obtained permission from each of these participants to contact them subsequently if additional information was required.

To maintain integrity of interpretation, the semi-structured interviews pursued a consistent line of inquiry guided by the five broad questions central to the research (Corbin & Strauss, 2008; Glaser & Strauss, 1967). Further exploration included concerns, issues and central concepts/categories arising from initial responses. These loosely defined questions for guiding the conduct of the interviews gave interviewees the freedom to recall and expand on events (O'Donoghue, 2007).

Interviews became progressively more focused as concepts were generated from ongoing analysis.

Quality of interview data is influenced by the nature of the relationship and rapport between the interviewer and participants with a good rapport increasing the chance of hearing the real story (Berg, 2009). Two weeks before interviews, participants received an overview of the research and an information sheet (Appendix 1) to ensure they had time for reflection on the focus of discussion. This was to enable optimal opportunity for rich data collection (O'Donoghue, 2007). All participants were encouraged to share their views and to speak freely about the research focus and were reminded that any experience they chose to share was of interest.

All fifty-five interview participants were cordial and cooperative and appeared genuinely interested in the research. The participants focused on the questions, taking time to consider them and provided expansive and honest responses to any question posed by the researcher. Participants offered personal insights in "telling their story" and demonstrated considerable trust in the researcher. All interviews were concluded with the researcher asking the participant if there "was anything else you would like to discuss". This provided the participant with the opportunity to ask questions, summarise their perspective or add further information not already discussed believed to be important.

The researcher acknowledges that the interview method has the potential to impact on data collected (Wimpenny & Gass, 2000) and was mindful that nonverbal communication also needed consideration in order to minimise both positive and negative impact during the interview. Therefore the researcher was particularly careful to check her responses, to provide no guiding cues, to demonstrate no non-objective, non-verbal cues, and demonstrate neutrality by not reacting positively or negatively to responses. She did not engage in feedback when participants attempted to elicit her view of a given situation and reinforced that there was "no correct" response or experience.

3.4.4 Audio Tapes and Transcripts

Interviews were audio-recorded as this method permitted full transcription of interviews (Bertrand, Brown & Ward, 1992; Sim, 1998). All interviews were audio-taped using two tape recorders, to provide the interviewer with the flexibility to focus the direction of the interview, provide a means of transcription and provide a backup if tape failure occurred. The interviews ranged in length from forty-five minutes to one hundred and forty-five minutes, with the average being sixty-nine minutes.

Interview notes were also made throughout interviews, while memos and observation notes were recorded immediately following each interview to log collaborating information that was not otherwise captured (Merriam, 1998). All transcripts were coded by notations to assist with ease of access in analysis and writing up the findings (O'Donoghue, 2007). Any distinguishing information was altered and/or deleted from the transcribed interview text. Although note taking was found to be a positive strategy that assisted in organising thought processes, the researcher found note taking easier during telephone interviews, as it tended to be a distraction for the participant during face-to-face interviews. Therefore, to minimise distraction, note taking during face-to-face interviews was limited to key outlier concepts only.

All fifty-five interviews were transcribed verbatim, with the consideration that transcription essentially requires rewriting 'the story'. As such transcription was both interpretative and constructive (Lapadat & Lindsay, 1999, p. 72). Each audio-tape was transcribed verbatim immediately following an interview and transcripts were subsequently audited for the quality of transcription where the researcher listened to the tapes numerous times.

During the transcription process a code was attached to de-identify the participant responsible for responses. To assist with verification and in developing a degree of trust in the quality of the transcriptions each participant received a copy of their interview transcript through email. Participants were requested to review the transcript for content and context and identify changes and/or make comments and return these via secure email. Fifty out of the total fifty–five transcripts were

returned. All feedback, including acknowledgment of transcript intent and accuracy were stored according to the confidentiality and ethical principles approved by Human Research Ethic Committees. At the completion of the interviews, it was necessary to search further for and to review literature relevant to the data collated in order to provide a framework to demonstrate final themes and concepts.

3.4.5 Advantages and Limitations of Data

While there are numerous advantages with the data collection methods proposed, there are also limitations. Reflection on these limitations and strategies to minimise their effects was addressed by the researcher throughout data collection. Appendix 6 provides a summary of these considerations.

3.5 Data Analysis

Data management and analysis in qualitative research are basically about storing and categorising the data, making sense of the categories and communicating the findings to readers. Creswell (2002) noted that, when trying to make sense of data, the first step is to organise the data to support the research methodology in order to capture the essence of the meaning of the data. This assists in the analysis and subsequent reporting of the data, as it informs the following round of data collection. Data collection and analysis were progressed simultaneously, with analysis becoming increasingly intensive throughout the research (Patton, 1990, 2002). The analysis of the data was undertaken through the application of the methods of Corbin and Strauss (2008) and Strauss and Corbin (1998).

The researcher was an 'instrument' of the research process, as the data analysis relied on the researcher's analytical and critical thinking skills to construct theoretical understanding through identification of meaning and connections found through the data (Strauss & Corbin, 1998). Interaction between the researcher and the data formed a key foundation of the analysis process (Strauss & Corbin, 1998). The researcher aimed to balance objectivity with sensitivity in order to maximise accurate interpretation of data.

As data collection and analysis were undertaken simultaneously, subcategories and categories were modified, accepted or rejected according to their validation or repetition in the existing data (Corbin & Strauss, 2008). Following transcription of each interview, the data were repeatedly read using an iterative set of procedures. The resulting notations of questions or concepts expressed by the participants were used to prompt further discussion in subsequent interviews, or to help develop themes of subcategories as they emerged (Huberman & Miles, 2002). To minimise development of poorly composed theory and as suggested by Strauss and Corbin (1998), this process continued until no new data were generated for a particular category and the properties and dimensions of each category were well developed with variation determined and establishment of relationships between categories.

3.5.1 Coding and Categories

In grounded theory, coding is a fundamental analytical process where raw data are separated into abstract pieces and cultivated to a conceptual level (Corbin & Strauss, 2008). Coding is used to open up the text, by unearthing what is contained in the data through interacting with the data, making comparisons, deriving concepts and then developing these into conceptual categories in respect to their proprieties and dimensions (Corbin & Strauss, 2008, p. 66.). Analytic tools such as listening to participants; not taking anything for granted; asking questions of the data; making comparisons to differentiate categories, use of personal experience to draw possibilities of meanings, review of language used and emotions expressed were used to identify the words, ideas, concepts, and examples that are symbolic of a category (what is revealed by the data) significant to the phenomenon being studied (Corbin & Strauss, 2008, pp. 67- 80). Coding procedures were applied in a flexible manner and reflected data gathering strategies, analysis and theory development. This process assisted the researcher to appreciate the research participants' experiences.

Analysis of data followed the process of open, axial and selective coding as outlined by Corbin and Strauss (2008). The open coding process involved the breakdown of data which were then examined closely and compared for similarities and differences, to inductively generate concepts. These concepts, according to

Corbin and Strauss (2008), are identified phenomena that are abstract representations of something in the data that the researcher considers significant. Labeling of concepts commenced at the beginning of the analysis process with data collection, questioning (theoretical sampling) and analysis continuing until new data failed theoretically to identify new concepts (Corbin & Strauss, 2008).

In the current research, initial data analysis occurred at a descriptive level and comprised re-reading the transcripts many times and adopting the language of the participants to create open codes (Corbin & Strauss, 2008). Initially line-by-line analysis was undertaken to identify words, phrases and themes relevant to the phenomenon being studied and to the participant story. Initial open coding via manual analysis of the interview data generated provided thousands of entries of similar words or terms with hundreds of preliminary codes. The accumulation of data was considered overwhelming and thus analysis was supported by the use of both manual and qualitative data analysis software (NVivo, 2006) throughout the process.

Corbin and Strauss (2008, p.198) present open and axial coding as 'hand in hand'. Thus axial coding was undertaken via analytic iterations at increasingly abstract conceptual levels, resulting in the generation of memos, conceptual codes, identification of categories and theory generation. The researcher came to recognise patterns generated and portrayed these as conceptual representations that added to understanding the experience of the phenomenon being studied (Corbin & Strauss, 2008). To assist with data management using NVivo (2006), these data were grouped by research group and category. This strategy assisted the researcher to track similarities and differences between research groups; and it provided a record of the actual words and terminology of the participants.

The researcher asked questions during the initial coding, such as why certain activities and views occurred and how they made the participant feel, and then made distinctions and comparisons regarding how some concepts pertain to context in which the participant worked. Corbin and Strauss (2008) suggest the use of a paradigm that can be applied to data to identify relationships between context and process. The basic components of the paradigm – conditions, interactions and

consequences – were considered by the researcher with respect to participant responses related to everyday descriptions about nurse educators (Berg, 2009; Corbin & Strauss, 2008; Strauss & Corbin, 1990). Consideration of the complex relationships between conditions and consequences and the subsequent chain of actions enhanced understanding of the circumstances surrounding events as a process to enrich analysis (Corbin & Strauss, 2008). Corbin and Strauss (2008, p. 90) caution that the 'paradigm is only a tool to obtain understanding and is not a set of directives'. Thus avoidance of identified shortcomings such as limitations of creativity and theoretical sampling choices (Corbin & Strauss, 2008) were heeded by the researcher.

As the coding progressed, similar codes were generated across data. Ongoing coding and analysis of data led to the generation of 62 provisional codes (Appendix 7). Each of these codes contained words, phrases or concepts with similar meaning. It is recognised that there is some degree of overlap in a number of codes, given that free-form discussion at interview had the tendency to translate across codes.

As noted, open and axial coding can occur simultaneously (Corbin & Strauss, 2008) and in undertaking this approach new ways of making connections between categories and subcategories occurred and some previously identified categories were renamed as subcategories (Corbin & Strauss, 2008; Backman & Kyngas, 1999; Strauss & Corbin, 1998). This was, in effect, a process of inductive and deductive thinking whereby the researcher returned to the data to look for answers to questions, such as why or how come, where, when, how, and with what results, and in so doing uncovered relationships between categories (Strauss & Corbin, 1998, p. 127). Through this ongoing process of deduction, the sixty-two provisional codes identified were re-established into eleven interim inter-related categories and multiple codes (Appendix 8).

The use of constant comparative analysis also permitted concepts to be grouped together and differentiated under higher-order abstract interpretations (Strauss & Corbin, 1998). The process of labeling concepts and grouping these into categories reduced the data to a more manageable form (Strauss & Corbin, 1998).

Identification of categories enabled additional development through further theoretical sampling, data collection and analysis, in order to identify the specific properties and dimensions of each identified category. Comparisons were made between participant interactions to inform the next incidence of data collection. Additionally, cross-analysis of data from other data gathering measures, such as the review of the literature and Queensland Health documents, was undertaken to identify regularly occurring concepts and to make comparisons with emerging concepts (O'Donoghue, 2007).

Constant comparative analysis of the data from the four sample group interviews involved comparison of codes and sub-categories that ultimately led to the generation of eleven preliminary categories and five provisional final categories (Appendix 8 & Appendix 9). Consideration of the substance of these related categories led to the generation of two major categories (Appendix 10). This method is essential for theoretical sampling and continued through the entire research coding (Strauss & Corbin, 1998). Data were collected and analysed simultaneously to determine what data to collect next and previous data were reviewed and re-analysed which assisted in re-designing concepts and codes which lead to core category generation and theoretical understanding (Strauss & Corbin, 1998).

Theoretical sampling was used to "maximize opportunities to compare events or incidents or happenings to determine how a category varies in terms of its properties and dimensions" (Strauss & Corbin, 1998, p. 202). Comparisons were made until a category was fully developed. Through this process the core variable *negotiating boundaries* was generated. Theoretical sampling undertaken in this research included not only data from interviews, but also an additional review of the literature. While the literature was initially examined at the commencement of the research, it was re-examined and a comprehensive review was undertaken during analysis to determine new information that would add to codes and new categories generated. The second review was not confined to contemporary literature, due to the limited availability of research articles on the contribution of the nurse educator to the continuing education needs of the nursing profession.

Selective coding was used to compare codes, categories and constructs that emerged from the initial analysis of data from the groups, in order to further refine categories. This process outlines a basic theoretical scheme and facilitated the identification of the core category *negotiating boundaries* and the ways in which the two major categories were related to the core category (Strauss & Corbin, 1998). The theory is refined through the removal of excess codes and as appropriate, developing categories through further theoretical sampling, data collection and analysis, unit theoretical saturation occurs (Strauss & Corbin, 1998).

Another factor requiring ongoing consideration throughout the coding process was the need for the researcher to remain constant to the grounded theory method of comparison, rather than searching for concepts, as this would have posed a substantive risk of developing core categories based on the researcher's intuitive responses to the data, rather than on rigorous analysis. In accordance with the perspective expressed by Patton (2002), during analysis the researcher attempted to construct a framework expressing the essence of what the data revealed through data–theory interplay without forcing interpretation (Strauss & Corbin, 1994, 1998).

Once data analysis was completed, theoretical writing commenced. This process, viewed as joining the findings together into a scholarly account, involved using the collated memos for each category and determining the 'core category'. Ultimately, two major categories related to the nurse educator's role and contribution to the nursing profession were generated from experiences and meanings expressed in participant interview data (Appendix 10).

3.5.2 Memos

The use of memos is fundamental to grounded theory as memos can provide a foundation that facilitates theory generation as well as a reflective process enabling the researcher to derive meaning from the data and time spent with participants to develop theoretical ideas (Mills, Bonner & Francis, 2006). Memos are a key tool in that they are generated during every stage of the research. They are used by the researcher to document thoughts, questions and feelings that contribute to the analysis, and they assist in generation of the final substantive theory and dissertation (Corbin & Strauss, 2008; Ezzy, 2002). Memos can be developed in whatever form the researcher considers relevant (Corbin & Strauss, 2008; Ezzy, 2002). In this

research memos were written as notations to record the researcher's thoughts and decisions, in note format, and as NVivo (2006) jottings. Memos generated were linked to an individual or concept, at the completion of an interview or during transcript reading and review, to identify aspects for further consideration, such as particular attitudes, views or concerns of participants, or to prompt the researcher to undertake some additional activity (Appendix 11).

3.5.3 Software Assistance

The researcher used NVivo qualitative data analysis software Version Seven (2006) to assist in the organisation of data obtained from interviews. Thorough attention was paid to coding, note taking and memo-ing during data analysis, following conventions developed by grounded theory scholars (Strauss & Corbin, 1998). The integrated search capabilities of NVivo (2006) enabled text and coding-based search processes to be integrated with attribute-based search processes, in the same search (Richards, 2005). This search capability assisted in comparative analysis of data, given the number of interviews (55) and consequent volume of data coding. However, there is some question regarding the use of computer software in grounded theory analysis, as the approach requires the ability to view the data as a whole and then leave the data (Goulding, 1999). Where software posed constraints at the higher levels of analysis, such as an inability to link abstract concepts or abbreviations commonly used by participants, manual methods were used to supplement the software, following the recommendations of Soliman and Kan (2004).

3.6 Determination of Rigour

What is rigour in interpretive research has been debated and addressed by numerous researchers (Morgan, 1998; Morse, Barrett, Mayan, Olsen & Spiers, 2002; Rolfe, 2006; Schneider, 2003). However, concerns over lack of transparency and confusion continue to be central considerations of this type of research (Sandelowski & Barroso, 2002). This, in turn, has influenced researchers to define what constitutes a good, valid, and/or trustworthy qualitative research. For example, Sandelowski and Barroso (2002) have argued against "epistemic criteria" for making judgments about qualitative research, claiming that the epistemological scope of qualitative methodologies was too broad to be characterised by any single

set of criteria. Rather, they have supported the perspective that qualitative research should be judged according to aesthetic and rhetorical considerations, identifying that "the only site for evaluating research studies – whether they are qualitative or quantitative – is the report itself" (p. 8). This current research's theoretical perspective of symbolic interactionism was chosen because of its focus on understanding how participant behaviours have been shaped through social interaction and interpretations in a particular content (Blumer, 1969; Milliken & Schreiber, 2001). This theoretical view provided the lens through which could be explored participant interpretations and constructions of experiences of hospital employed nurse educators. The research also considered how social structures (such as power, organisation, culture, emotions) shaped individual behaviour. The combination of constructed experiences and social structures located this research within the theoretical framework of symbolic interactionism.

However, it rests with the researcher to find the most appropriate measures by which to assess rigour, by ensuring that these measures provide accurate expression of the methodical assumptions being used in the research (Koch, 1996; Roberts & Taylor, 1998). With these considerations in mind, the indicators of rigour predominately applied in this research were the criteria described by Corbin and Strauss (2008) as the purpose of the main intention of this grounded theory research was to develop a theoretical appreciation of the participants' world and interactions within that world (Janesick, 2000).

Corbin and Strauss (2008, p. 299) acknowledge that Lincoln and Guba (1985) propose collective criteria for establishing the trustworthiness of qualitative data such as credibility, dependability and transferability which includes activities such as: peer review, member checks, clarification of researcher bias. However, Corbin and Strauss (2008, p. 299) contend that "these criteria are directed more at validity aspects of doing qualitative research rather than the creative." What is apparent is that when using qualitative data there is no single way to assess rigour and that a balance between demonstrating rigour and displaying creativity is obtained by the researcher (Corbin & Strauss, 2008; Patton, 2002).

Qualitative research is based on subjective, interpretative and contextual data; consequently, the positivist belief in truth and value and rigour strategies applied to quantitative research are not wholly applicable to qualitative research (Maxwell, 2005; Strauss & Corbin, 1998). Qualitative researchers primarily work from the perspective that research findings are the result of interpretative undertakings with the researcher being an active part of the process and thereby having potential to influence the results (Morrow, 2005) and to ensure results are trustworthy (Sandelowski & Barroso, 2002). Therefore, it is important that rigour is built into the qualitative research process rather than imposed retrospectively (Corbin & Strauss, 2008; Glaser & Strauss, 1967).

Overall the researcher applied criteria proposed by Corbin and Strauss (2008, p. 305-307) to faciltate evaluation of the quality of the research findings of this research. The first was ensuring that the findings fit with the experience of the participants and groups who particpated in the reseach. Consideration was also given to the usefulness of the findings and whether they make sense. Reflection regarding the depth of findings and what they add to knowledge and practice was undertaken with findings also compared to existing literature. Care was taken in the presentation of findings in the endeavour to facilitate reader ability to understand why meanings have been attributed. Attention was given to consideration of reader perceptions so that they would not feel that essential aspects of the story are missing. Additionally the researcher was mindful of the research theoretical framework and methodolgy and implemented multiple strategies to ensure that the analysis drove the research, not the researcher.

Research participants had the opportunity to review and make comment on collated data and interpretation through a review of their interview transcript. Memos were used to keep track of insights and analytical ideas during data collection and analysis and to keep the researcher aware of their biases or assumptions (Corbin & Strauss, 2008).

To demonstrate that the findings of this research may have meaning for others in similar situations, literature relating to each category was sourced as another form of data to facilitate understanding. The literature was also searched for

findings that referred to a similar phenomenon, although no direct alignment was found. Details about the research sample and setting characteristics were also provided to aid reader assessment of the transferability of findings. If colleagues review the research and believe it to be relevant to their particular situation, its findings may be considered transferable. However a decision of transferability is the responsibility of any individual considering the findings and not the researcher of the original research (Barbour, 2005).

This research included generation and maintenance of an audit trail of systematically collected resources to be examined by two independent reviewers. The reviewers for this research were the researcher's supervisors, who are experienced in research methodology and know the research focus. The supervisors reviewed each aspect of the research at predetermined times and provided ongoing feedback and direction in relation to the development of theory (Bassey, 1999; Webb & Kevern, 2001). A trusted colleague familiar with the research focus also reviewed the findings and the theory meanings generated.

3.7 Ethical Considerations

Exploration of thoughts and perceptions regarding public sector nurse educators were central to this research. This exploration was guided by the fundamental principle of safeguarding the human rights of the research participants. Considerations in this research included obtaining informed consent, facilitating good communication, using appropriate data storage and ensuring confidentiality.

3.7.1 Approval Considerations

Prior to commencing data collection ethical clearance was obtained (Appendix 12). This proved to be a well-scrutinised and in-depth process that required Human Research Ethics Committee approval from the Queensland University of Technology, each of the eight Health Service Districts, and the Queensland Health Ethics Committee. In addition, the Queensland Health Human Research Ethics Committee required a face-to-face interview to discuss the application of grounded theory methodology in respect to the research. The Committee recommended that strategies to minimise perceptions of "power differential" because of the researcher's substantive position in Queensland Health be clearly articulated.

In addition to these ethical approvals, administrative clearance to proceed with the research was obtained from the Area Health Service General Manager and each participating Health Service District (Appendix 13). At the time of obtaining clearance, all Health Service District Managers were advised in writing of the research intent, the expected time frame for interviews (e.g. sixty minutes), an estimate of numbers of participants from each Health Service District (HSD) and the approximate cost to the HSD related to staff participation in the research. The Area Health Service and all HSDs approached fully supported the research and agreed to absorb the nominal one-hour cost of participant participation into operational budgets. The District Directors of Nursing in each of the eight Health Service Districts provided approval to proceed on behalf of Nursing Services in each HSD and offered encouragement as well as support for the research. After two submissions over a six-month period, all perceived concerns were addressed and all approvals to proceed to data collection were obtained.

Each participant was provided the opportunity to ask questions of the researcher, both prior to and after signing the consent form. The scope of the research was outlined and confidentiality stressed prior to commencement of the interview. Prior to commencing the interview the researcher also reiterated that there were no preconceived ideas in relation to the research findings and that participants could refuse to respond to any question and were free to withdraw from the research at any time. In the latter event any information provided would be destroyed at the participant's request. The ethical principle of autonomy was observed to ensure that consent was informed and given without duress, and participation took place at the participant's choice, with no element of duress, or similar unfair manipulation (Webb & Kevern, 2001). On completion of the consent form participants completed a tear-off section to indicate whether they would like the aggregated results of the research forwarded. Demographic Survey consent was implied by voluntary return of the completed survey form by the participants. Data gathering ethical considerations are summarised in Appendix 14.

Prior to data collection, there was some expectation by members of one Human Research Ethics Committee that the researcher would have to initiate additional measures, such as reassurance with respect to the researcher's obligations,

participant confidentiality, and encouragement, to identify any misgivings participants might have in relation to the application of the research or protocol given the prominent position of the researcher in Queensland Health. However, these additional measures were not required, as no participant expressed any concern regarding possible negative impacts associated with participation. Indeed it was articulated by participants, on numerous occasions and from every sample group, that they were only 'too willing' to be involved in the research, as most considered it long overdue and were pleased that an 'insider' who had a clear perception of the 'situation' was the researcher. Further, several line managers, nurse unit managers and the majority of the nurse educators were clearly passionate about their perspective of the research intent, expressing the view that not only was the research important from a professional perspective, but they additionally hoped for some personal and/or professional gains and insights from the research's findings.

3.7.2 Data Storage

Data storage in this research complied with the National Standards on Ethical Conduct in Human Research (Australian Government, Research Council, 2007) and with the requirements of each Human Research Committee that approved the research. Collected data will be retained in aggregated or coded format as hard copy, CD-ROM and USB for seven years in a locked cupboard in a secured environment accessible only to the researcher. After the nominated period, all data forms will be responsibly destroyed. Only aggregrated research results will be made available to Queensland Health and line managers.

3.7.3 Integrity

The majority of participants in this research knew the substantive organisational position of the researcher. A number of ethics committees were concerned that for this reason there was some potential for power differential deferential intimidation of participants, and for confidentiality to be compromised. To counter these concerns, the ethical strategies outlined were applied to promote participant trust in the research process. Such apprehensions did not appear to eventuate, as all participants actively participated, with no hint that any felt intimidated, and indeed numerous participants demonstrated considerable trust by freely sharing 'sensitive' information.

All research participants were employees of Queensland Health (Nursing Classification) and all were colleagues of the researcher although with no direct line-reporting relationship. During all stages of the research the researcher adhered to the Queensland Government Code of Conduct (2011), Industrial Relation Policies and the Australian Nursing and Midwifery Code of Conduct (2003), Ethics (2005) and Professional Conduct (2006b) for nurses in Australia.

3.8 Researcher Reflexivity

Before commencing the research, the researcher embarked on an extended self-awareness process, by taking time to introspectively analyse self-values, perceptions and attitudes in an endeavour to maintain objectivity and limit the potential for introducing bias. This process involved reflection on her own views of the role, discussing these and potential impacts with supervisors, and not allowing personal views to intrude or guide any aspect of interview interaction. Importantly, it must be recognised that values, perceptions and attitudes are unable to be totally put aside to avoid introducing bias. Instead these were used to assist in developing sensitivity to the meanings in data. Strauss and Corbin (1998) proposed that it is impossible to disassociate one-self from "who we are and what we know" (p. 47). However, in line with the theoretical perspective of symbolic interactionism, since the researcher has shared common situations with the group, the ability to recognise patterns of behaviour while maintaining an individual perspective was enhanced (Blumer, 1969). The approach was supported by the research interpretive paradigm, since an in-depth understanding of the nurse educator position facilitated an 'insider' appreciation. Personal exploration and analysis of accepted symbols were enhanced, as was a sound grasp of how these are maintained and/or adjusted within the specific context. Strauss and Corbin (1998) affirmed that it is appropriate to use this knowledge to enhance sensitivity to the meanings in data, while avoiding forcing one's own view on data.

The researcher maintained objectivity in the research process by preserving an openness and willingness to fully engage with participants, while at the same time focusing on the participants' rights to be heard and to express themselves in their own words. A means of maintaining this objectivity, offered by Strauss and Corbin (1998), is to gain wide ranging data, to compare data to other data, to

validate interpretations with participants and to maintain an attitude of skepticism, regarding all interpretations as provisional until they are validated against further data. This perspective enabled the researcher to cast aside some of her own perceptions and knowledge of the nurse educator role while critically analysing data obtained and reducing bias when interviewing participants. The researcher as an 'insider' maintained an open mind to the possibility that the research may give rise to an entirely new way to view the role and contribution of the hospital employed nurse educator. Morse (2001) suggested that one means to avoid researcher assumptions related to the topic is to conduct the research in new settings so that the researcher is a stranger and not completely comfortable. Accordingly research participants were recruited from a variety of healthcare settings including settings outside the researcher's workplace.

With respect to both new and familiar research contexts, a challenge lies in the researcher's ability to identify both the complexity of the social relations and how her own position is constructed within the reality of the context studied. Therefore, it was important that the researcher engaged with participants. The researcher was an 'instrument' for data collection, and as such she was in a position to use knowledge and experience to obtain a better understanding of the phenomena (Rice & Ezzy, 2001). As previously acknowledged, personal insight may distort the research; however, it may also offer an insight that would otherwise not be understood. The researcher (holding a substantive position of Nursing Director (Education) in a Health Service District participating in the research) acknowledged that having intimate knowledge of the people and the customs and practices may have negative implications such as preconceived perceptions of the role or views about individuals. However, familiarity with settings and individuals should mean that the researcher is less likely to be misled by incidences such as inaccuracies or anomalies in reporting role, nursing education model, numbers of nurse educators employed and support strategies. Conversely, familiarity can lead to important details or concepts, such as work load, interactions and valuing, being missed or taken for granted (Rice & Ezzy, 2001). To counter this potential, meetings between researcher and supervisors were undertaken regularly throughout the course of the research. As the supervisors are less aware about the contribution of public sector nurse educators to the continuing education needs of the nursing profession,

questioning by supervisors assisted in overcoming assumptions and omissions related to 'insider' knowledge.

As the researcher fulfilled a substantive line-management position within one of the recruited Health Service Districts, none of the nurse educators reporting directly to the researcher's position were included in the research. While the researcher did not have direct line supervision of any participant recruited to the research, participants who knew the researcher potentially could be inhibited during interviews, which would negatively impact on the quality of data collected. To counter this possibility the researcher attempted to distance herself from her substantive nursing position. In so doing, at the commencement of each interview, she reinforced for each participant the research intent, highlighting that the research was being undertaking from an independent perspective, with no direct relationship to the researcher's substantive nursing position. Instead she presented herself as a researcher and requested that each participant view her in this role. Additionally, interviews were conducted in the researcher's personal time whenever possible; to further enhance perception of a separate role. Comments from participants regarding how the research may impact on roles and/or requests for clarification from the researcher's substantive position, were acknowledged, then re-phrased into questions and re-directed to the participant to consider in respect of the intention of the research.

The researcher also acknowledges personal preconceptions of and attitudes towards the research topic, as she is an 'insider' with over twenty years of experience at several levels of nurse education. While this status is useful for demonstrating sensitivity and empathy to participants it was also recognised that existing beliefs, expectations, assumptions and past experiences could be a barrier to objective and inductive data analysis (Strauss & Corbin, 1990). Therefore, the researcher was actively reflective in order to ensure a balance between objectivity and sensitivity (Barker, Wuest & Stern, 1992).

The researcher also attempted to disengage herself as much as possible from her substantive position as a leader and manager of nurse educators by adopting an 'open minded approach', while focusing on the patterns found in empirical data rather than inferences, prejudices or association of ideas. This was achieved through the use of deducted reasoning and robust discussion with supervisors, as well as being open to the possibility of findings contrary to current practice (Strauss & Corbin, 1998). Accordingly, reflective memos regarding researcher perceptions and concerns were written, discussed with supervisors and, where relevant, compared with other theories (Smith & Biley, 1997).

Additionally, the researcher was mindful that if data were not collected within a certain timeframe and analysed simultaneously, it would be difficult to determine theoretical shape and to recognise when no new ideas were being generated (Backman & Kyngas, 1999). As a 'novice researcher' care was taken not to form conclusions based on provisional analysis as this may have impacted negatively on further data collection and analysis (Corbin & Strauss, 2008). This was considered and countered in this research by completing the fifty-five interviews and transcriptions over a seven-month period of data collection and concurrent analysis. In addition, progressive analysis of findings and researcher perceptions of what the data were 'saying' were presented and discussed with the supervisory team to minimise 'forcing data' conclusions.

Moreover, from the time the research intent was publicised through facility directors of nursing and nursing directors, education the researcher was inundated by colleagues volunteering either to be research participants or to assist in the progression or support of the research. During data collection, all participants arrived at the mutually agreed interview time and no participant withdrew from the research. Participants were encouraged to be expansive, honest and frank when taking part in the interviews. The researcher was very impressed with how open, frank and willing participants were to share perceptions, with implicit trust being shown through the researcher's professionalism and confidentiality. Furthermore, at the commencement of the interview the researcher stressed that she had no preconceived views regarding the research findings, nor did she have any intention of attempting to guide participant responses in any particular direction, but would be

relying on the data to guide findings. Participants were also advised that relevant research findings would be presented in aggregated form only, so if the research findings recommended a wide-ranging 'rethink' regarding the application of nurse educator roles, then this perspective would be presented as seminal findings.

Hence, although the recommendations of this research are based on careful and systematic investigation there remains an appreciation that the findings offer no absolutes (Bassey, 1999; Blumer, 1998). This premise is assumed because findings are based on interpretations of interactions and as such are prone to some degree of subjectivity as humans are thinking, feeling and responsive entities, not passive objects of research (Norton, 1999).

3.9 Conclusion

An interpretative design was adopted for this research. This chapter engaged with the theoretical tenets of symbolic interactionism as they informed data collection and analysis. The grounded theory approach of Strauss and Corbin (1998) and as refined by Corbin and Strauss (2008) was applied in this research. The methods of data collection and analysis and strategies to ensure a reflexive approach were argued in detail. Explanations of interpretative research rigour and ethical considerations impacting on the research have also been identified and expanded. An overview of the research design used in the research is provided in Appendix 5.

Chapters Four and Five present the findings from an analysis of data generated from interviews with fifty-five participants. The analysis, while systematic, was non-linear and involved a constant process of comparisons and integration of interpretation, theory and literature. Thus, in subsequent chapters, each generated category and sub-category is explored in relation to existing literature and within the context of the findings and interpretations. Each category was formed through a process whereby the researcher reflected on her own analytical perceptions and through an exploration of the ways in which the research participants constructed their worlds (Blumer, 1969). The process of re-examining data and audit trail strategies assisted in the modification and refinement of categories, sub-categories and in their substantiation. Key understandings such as nurse educator visibility, relationships, value, safety net and contributions of the role

are examined. The outcome was the development of two categories: *reflecting on attributes and expectations* and *constructing workplace learning.*

Each category chapter addresses findings and exemplifies variations that exist in the perceptions of nurses across a range of professional positions and within the contexts of hospital employed nurse-educators. The categories form the basis of theory development and underpin the generation of the socially constructed meanings about the role and contribution of the hospital employed nurse educator. In the following chapter, the first of the categories and sub-categories generated from the analytical process are examined and theoretically developed. The focus of Chapter Four is the category *reflecting on attributes and expectations.*

CHAPTER 4 – REFLECTING on ATTRIBUTES and EXPECTATIONS

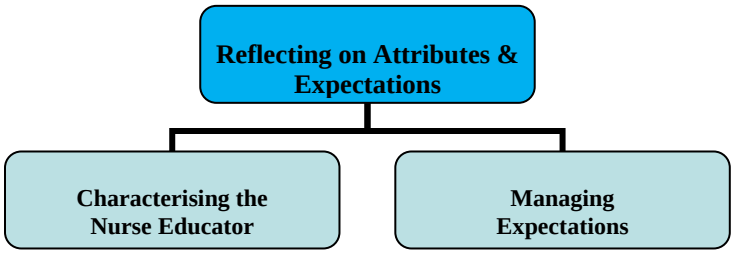
4.1 Introduction

The intent of this study was to theoretically explore, through the perceptions of four groups of nurses, how the hospital employed nurse educator is situated within the clinical nursing structure and how the contribution of this sector to continuing professional development is perceived. This chapter engages with the category, *reflecting on attributes and expectations,* generated from analysis of interview data. The chapter explores the interpretation of the nurse educator role and how professional boundaries add to the complexity of this role. The chapter commences with an explanation of the processes underpinning the category through the two constituent sub-categories, *characterising the nurse educator* and *managing expectations*. Each of these is addressed in turn.

4.2 Reflecting on Attributes and Expectations

The category *reflecting on attributes and expectation*s explores participant perceptions of the role attributes of public sector employed nurse educators. Evaluation of this category concentrates on the role of the nurse educator and how the boundaries they encounter influence both their actions, and the outcomes they achieve. Conflicting views on what is expected of this role are considered within the context of nurse education services. More specifically, these differences are addressed in each of the two sub-categories depicted in Figure 4.1.

Figure 4.1: Category – Reflecting on Attributes and Expectations



The term role typically refers to behaviours expected of individuals who occupy particular social categories which can be informal and formal (Montgomery, 1998). However, the interactionist meaning of role is as a social process wherein performance is constantly negotiated and continually readjusting (Blumer, 1969; Mead, 1934). Mead (1934) contends that to enact a role one must put oneself in the place of others to view the world as they do, using prior experiences, knowledge of social groups in which others are located and symbolic cues to guide interaction.

Thus the interactionist view of a role is that it is not fixed but something that is reformulated by individuals in an ongoing, tentative and creative manner (Blumer, 1969; Mead, 1934). Hence the interactionist meaning of role places the focus on a changeable and readjusting social process. According to Lynch (2007), the process of interaction deterministically shapes the way personality, behaviour and society are organised. The argument here is that, based on subjective perceptions and preferences, individuals attempt to coordinate their behaviours with others and jointly define what comprises a given role. Or as Stryker (1991) pointed out, individuals "make" the roles they enact.

Nonetheless, Lynch (2007) also contends that the context, situation and value attributed to role performance may mean that understandings attached to roles are not always shared. Where meanings are not shared, problems in role taking and role making may occur and lead to role conflict and a need for role accommodation within the individual (Stryker, 1991). This means that, in response to possible role conflict, individuals align their actions to others and to the social context whereby they act in a manner thought appropriate to the situation.

The nurse educators adjusted their role states as part of their daily experience. Thus, while the educators maintained an intense cognitive focus on the boundaries of their role they engaged with the behavioural elements of others. As such, they demonstrated role flexibility and adapted ways of thinking and behaving to balance different views of role enactment. They did this to gain acceptance of a role that is not readily understood, and to expand support for workplace learning in an environment where the predominant focus is on clinical care.

The majority of international and national literature examines the nurse educator role in terms of undergraduate student support, specific clinical nurse educator/teacher roles, academic faculty roles or preparation to undertake the roles (Christiansen, 2011; Conway & Elwin, 2007; Forbes, 2006; Manning & Neville, 2009; McSharry, McCloin, Frizzell & Winters-O'Donnell, 2009; Pelletier et al., 2000; Ramage, 2004; Sayers & DiGiacomo, 2010). Confusion regarding terminology used to describe nurse educator roles and context identified in the published literature made it difficult therefore to interpret, compare and contrast roles, responsibilities and research outcomes. Contextual conditions, role attributes, work environments and/or award classification (pay and requisite qualifications) were either not addressed in this body of work or differed from the conditions in this research (Christiansen, 2011; Clifford, 1992; Conway & Elwin, 2007; Manning & Neville, 2009; Queensland Health, 2010a; Sayers & DiGiacomo, 2010; Swihart, 2009). The same confusion, however, is indicative of a lack of consistency in the construction of education roles and responsibilities across sectors.

Since the transfer of Australian nursing education to the higher education sector in the early 1900s there has been considerable focus on hospital employed nurse educators and their capacity to respond to changing organisational, clinical and professional expectations. Until recently and across the nursing profession, a perception has endured that this group functions as it did prior to the transfer of nursing education programs. Thus, while nurse educators are increasingly acknowledged by organisations and colleagues a discrepancy persists between the image of the hospital nurse educator and the realities of their practice.

In the research context, the projection of the ideal image of the nurse educator differed in accordance with expectations. In the first instance, however, while interpretations varied on what constituted the nurse educator role and how that role was enacted no participant group viewed the position as superfluous and thus redundant. On the contrary, the role was seen as valuable and any move to abolish or outsource it would be lamented and resisted. As was noted:

> If they got rid of the educators, eventually the skill mix and the skill level would deteriorate in my personal opinion…The educator is integral to professional development. IDI CN 1 (4). L 164 / 298.

> If there were no nurse educators it would be devastating as this Health Service District would be much worse off as who would support clinical staff… It is impossible to consider nurse educators as unnecessary. IDI LM 1 (12). L 34.

Moreover, participants noted that staff learn more and develop quicker with the support of nurse educators than they would by themselves as the nurse educator's appreciation of the context, shared views and values would be greater than others contracted for specific programs. As one nurse unit manager explained:

> Not having nurse educators and using an outsource model would not be responsive enough for me. Under that model if there were incidents or I had changing needs in my department it would take too long to be able to line up an external system to address immediate needs. Nurse educators are available and able to address immediate education needs and or issues. IDI NUM 1 (2). L 465 / 469.

The line manager (District Directors of Nursing; Nursing Directors, Clinical and Nursing Directors, Educators), nurse unit manager and clinical nurse groups shared the perception that the nurse educator fulfilled an essential resource support role. This was as a resource that fulfilled core activities and thereby reduced the workloads of others who did not have the time, interest and/or skills to fulfill a nurse educator role. The educators routinely provided development opportunities, resources and information that others could not offer. It was noted that practice standards would be reduced and attrition increased if hospital employed nurse educator positions were removed. Furthermore, if the nurse educator role did not exist it would need to be replaced by another, similar position. The following excerpts reflect this view:

> From my point of view I would be alarmed because I do not have the capacity to ensure that my staff are meeting the required competencies and standards annually. IDI LM 1 (6). L 165

> It is an extremely valuable role and it certainly makes my life as a nurse unit manager easier personally and organisationally. I feel that I don't have to drive all the education stuff. I very much support the educator role within our system and hope it doesn't change. IDI NUM 1 (3). L 438 / 442.

As the key actor in constructing a culture of learning nurse educators encouraged others to take responsibility for the translation of knowledge into practice amid a collection of complicated social relationships. The following nurses noted that:

> It's like a rabble, a rowdy group of uncoordinated (nurses) and so the nurse educator acts as the glue to hold them together to support people and when they're working in such a busy environment, we need to recognise that we're not just do it, we're thinking…So they need to promote nurses as thinking people, investigating, questioning and enquiring people, who are prepared to look at their practice, prepared to recognise that they may not have been doing what is um based on the evidence and the literature…The nurse educator has a great role in contributing to and promoting investigation, research and evidence based practice because the team is caught up in day to day work. Additionally they contribute as support people assisting people to learn a role and making sure they maintain a standard. IDI CN 1 (1). L 120 /136 / 200/ 202.

> I see her doing research and providing advice to me or (the) executive about what we should be doing in areas for professional development and individual development. IDI LM 1 (6). L 185.

However, participant groups differed over nurse educator workloads, expertise, attributes and role effectiveness. Underpinning these differences were vested interests and a desire to maintain the status quo within work units. Nurse educators, on the other hand, accommodated differing expectations in an effort to be socially and professionally accepted.

Line managers, who were resourced in 2007 with nurse educators following the Queensland Health Review (Forster, 2005), were positive about the role and outcomes achieved. They noted that nurse educators had the capacity to troubleshoot and review existing practices in an impartial manner, as well as assist nurse unit managers and other stakeholders to change historical practices to those based on evidence. These participants agreed on the effectiveness of, and need for, nurse educators in maintaining standards of care.

> If nurse educators were to vanish from the environment it would be detrimental to the people's opportunity to enhance their skills and it would be detrimental to the patients because it wouldn't enable us to continue to actually look at standards of care and how they are to be maintained and enhanced. IDI LM 1 (6). L 54.

The significance of the nurse educator position has been addressed in a range of contexts (Adrianne, 1996; Christiansen, 2011; Conway & Elwin, 2007; Hughes, 2005; Lepine & Ahola-Sidaway, 2000; Mateo & Fahje, 1998; Queensland Health, 2010a; Ridge, 2005). These authors all argue that nurse educator positions are important in maintaining the currency of skills of nurses and in integrating staff

practices and learning in the workplace. While the position was deemed important, however, knowledge of the role varied depending on vested interests, personalities and perceptions of power.

Shared meaning requires reflection on context, culture and the assumptions that are brought to relationships to find some common ground with colleagues. While shared understanding and effective professional relationships are important inconsistencies around relationships between nurse educators and other participants were evident in this research.

The relationships that nurse educators formed were considered important in shaping understanding of the contribution of the role. Thus personal values cannot be divorced from work roles and accordingly the quality of collegial relationships was dependent on daily workplace realities. One nurse educator explained:

> It is impossible to achieve what I should if I don't have collegial support. It doesn't matter what knowledge and skills I have if the staff don't work with me and see the value of what I do then I'm not going to be able to do my job properly. They like to see me and when we work together I need to earn their trust. IDI NE 1 (8). L 153.

Learning to act in a way considered appropriate is a process of ongoing socialisation that features in all interactions and assists in the appreciation of others' perspectives so that joint action can occur (Denzin, 1989). However, social interaction does not guarantee true connection and cooperation and lack of social support can lead to stress and conflict (Karasek & Theorell, 1990) Building relationships is a difficult process as one attempts to fit one's actions with others through the process of undertaking a role (Mead, 1934). Ensuring validation from others became problematic for the participants when colleagues interacted with the educators in unexpected ways and viewed role characteristics variously.

Only line managers with insider knowledge (e.g. had worked as a nurse educator, or had educational qualifications) and those in the nurse educator role were able to articulate what they considered desirable attributes and the problems educators encountered in engaging with staff where clinical workloads were the priority. Predictably, those without insider knowledge demonstrated little

understanding of the role and its complexity. Here knowledge was mediated through feedback from stakeholders including line managers and nurse unit managers and through interactions with educators.

One explanation of the above was that, while the role was perceived as integral to facilities and clinical work units, no consistent model of continuing professional development was identified across the eight Health Service Districts that participated in the research. A review of Queensland Health Documents (Queensland Health, 2007c, 2008a, 2006a, 2010a) and line manager confirmation indicated a lack of consistent and/or standard modeling of nursing education and nurse educator support between facilities and across the districts. This created confusion for line managers and service users over outcomes to be achieved, reporting requirements, education activity, and nurse educator engagement. Different models exacerbated nurse educator role confusion and the educators were constantly re-framing attributes and re-negotiating actions and interactions based on differences in role interpretation. A participant explains:

> I definitely think there is discord in how the role is viewed and what is expected of those in the role which may be influenced by personalities, culture and the model of education and support offered. IDI LM 1 (11). L 28.

Differing views on what comprised role attributes and how the role was applied in the workplace were evident particularly where the leader of nurse education (line manager) was not well versed with either nursing or education requirements. Furthermore, in facilities where more than one nurse educator was employed in a specific service (e.g. three nurse educators employed to undertake education support across four work units each), nurse educators often acted in isolation or responded to individual line manager needs rather than those of the job description, service or organisation. This led to inaccuracy in role taking and caused uncertainty regarding role intent, application, and outcomes. The following data highlights the disparate views surrounding the educator role:

> It's a very autonomous role; it doesn't have a lot of direct supervision or to a large degree direct accountability for what they have as performance outcomes … I have trouble articulating in my own mind exactly what they do. Behind the scenes it is sort of blinded to people what they actually do but they do contribute a lot to our service. IDI LM 1 (13). L 16 / 467.

> I report to a non-nursing line manager. I think it's again the profile. They're just not aware of what people have to do and I mean that as my current manager isn't a nurse. IDI LM 1 (14). L 484 / 524.

As such, while the nurse educator functioned in an infrastructure support position how this role was perceived depended upon context. In drawing on Goffman's (1959) understanding of social roles, the nurse educators were like actors constantly on stage where their performances were judged in terms of how others viewed their activities. Goffman (1971) referred to this process as the collective manufacture of roles which means that the cultural context within which a role is played out creates the possibilities for that role. Similarly, nurse educator effectiveness was determined on the basis of contextual expectations rather than the formal requirements and responsibilities of the role. Thus understandings of the role did not always align with position descriptions, nurse educator views and expectations. The following excerpts reflect participant views on the understanding of the nurse educator role:

> I don't think there's much wrong with the nurse educator role. I could say a lot more about what's wrong with the attitude to education as it is not always seen as essential. IDI CN 1 (4). L 92.

> I guess understanding other people's roles is actually challenging unless you are in them. You understand why the perception can grow but the other thing is that I don't think that general staff have an appreciation of the breadth of staff that are being supported by a single position. So you know for staff members, they think about it in terms of what do I get from the educator. And they may not be getting much because the educator's role is diverse and additionally the educator needs to influence through other people and so the educator influence on the clinical nurse teacher group is how they reach out to a wider group of staff. But those staff may not see that. IDI LM 1 (1). L 71.

The views of line managers tended to focus on the outcomes expected of a nurse educator, the strategic intent of the position and the need for the role. The interpretations of the clinical nurse group concentrated on operational aspects such as nature and extent of individual interaction with a nurse educator. As such, while the functions of the nurse educator were complex and difficult to articulate, there was disparity over what the functions comprised and what attributes should be demonstrated.

> A typical day of a nurse educator … is probably very multi tasked and sometimes can be a planned approach and others in probably a more reactive responsive way. IDI LM 1 (12). L 12.

Hence context was important in the research and nurse unit managers and clinical nurse groups focused primarily on how the educators impacted on their own roles and specific needs:

> …what the educator should be providing and what the nurse educator's job description is, are probably two different things … They can only be bothered with how you can help. They are busy and they don't want to know about the rest. IDI LM 1 (12). L 64.

Nurse educators reported that they were often uncomfortable and unsure of the expectations of, for example, nurse unit managers and how they should best respond. This had the potential to undermine the effectiveness of the role where nurse educators were unable to interpret relevant cues to make a transition to meet expectations (Becker, 2005, p.119). The Queensland Health Review of the Nurse Unit Manager Role (2008b), however, did not consider relationships between nurse unit managers and nurse educators as important to cooperation, even though the intent of the review was to strengthen enablers that support the nurse unit manager. In the current research an absence of shared meanings made relationship building difficult and at best superficial. Two participants noted:

> There needs to be a very high degree of support between the nurse unit manager and educator for things education and workforce development to happen smoothly. IDI CN 1 (7). L 222.

> If there were personality or communication clashes between the nurse unit manager and the nurse educators then the culture of learning and development of staff could suffer. IDI NE 1 (11). L 64.

The nurse educator position is generally perceived to be necessary to the health care workplace. However, disparate views over role attributes and effectiveness arose from differences in expectations between groups. These culminated in misperceptions of nurse educator role application and achievements. Findings for each of the two sub-categories comprising the category *reflecting on attributes and expectations* are explored in detail in the following sections.

4.2.1 Characterising the Nurse Educator

They don't know what we do but would be unhappy if we weren't there.

The sub-category, *characterising the nurse educator,* depicts an intersect between the complexities of the role, its attributes and hidden aspects. Participant groups identified common role attributes such as support, facilitation of learning and development, communication and leadership. However, lack of knowledge of the nurse educator position resulted in difficulties in identifying the skill sets associated with the role.

Attributes ascribed to the role of teacher or educator in the literature (e.g. teaching, developing programs/sessions, assessment and evaluation, facilitator of learning) aligned to some of those appearing in this research. However, they do not explain additional attributes (e.g. clinical skills and credibility) and expectations (e.g. visibility and engagement in clinical work units), the multifaceted decision making required of nurse educators (e.g. the need to be adaptive and fit into the changing workplace context) and the increasing complexity of health care and related environments. It is broadly acknowledged that nurse educators must be able to negotiate and demonstrate flexibility if they are to be effective in helping and supporting nurse employees to demonstrate best practice standards (Billet, 2004; Challis, 2001; Gallagher, 2007; Lombard, 1990; Shanley, 2004). Yet, existing knowledge of the nurse educator role relates primarily to characteristics of the role, rather than to their contribution to the ongoing professional development needs of the nursing profession (Christiansen, 2011; Conway & Elwin, 2007; Manning & Neville, 2009; McSharry, et al., 2009; Ramage, 2004; Sayers & DiGiacomo, 2010; Shanley, 2004). The literature is simplistic in this sense, in reducing the complexity of the role to generalisations.

The issue above is arguably not constrained to the nurse educator. Other research has similarly found that nursing generally does not develop as a linear process but demands multifaceted decision making and ever-changing skill sets (Bartletts, 2005; Gallagher, 2007; Gristic & Jacono, 2006; Ramage, 2004; Shanley 2004). Nurse educator work is directly related to what nurses do and as such a nurse educator has a difficult and crucial role in assisting nurses to negotiate their health care environments (Bartletts, 2005; Conway & Elwin, 2007; Gallagher, 2007; Gristic& Jacono, 2006; Ramage, 2004; Shanley, 2004). It may be, therefore, that the complexity of the nurse educator role makes it difficult to articulate or measure.

Indeed, and as noted, there was little participant acknowledgement of the complexities of the nurse educator position and particularly what constituted the hidden role. The hidden role referred to those functions the nurse educator undertakes primarily outside the clinical work unit. In other words, these were the elements that were not immediately visible from a clinical practice perspective but, nonetheless, were core to the educational role. Hidden roles were identified as program and session development, marking assessments, resource development, and confidential consultation support to colleagues, data entry and evaluations. Those in nurse educator positions and line managers who had formerly been nurse educators had insight into this area. The following data demonstrate understanding of nurse educator position requirements:

> I think most people have a limited view and understanding of what the nurse educator does and they probably only see the public components of what an educator does at the points of time when they may be involved. Most staff don't see what most staff do anyway, they don't understand the role of the Nurse Unit Manager often, and they don't understand my role or the Nurse Manager's role. IDI LM (7). L 38.

> Certainly when I go on holidays and somebody comes in and acts in my position, they just say I didn't know that you did all this. I didn't know that all this comes under your role. They don't really have a concept they don't see all the little bits and pieces and the things that you actually do so they don't understand the role. They see me teaching but don't see the stuff that you do behind it. IDI NE 1 (19). L 81 / 102.

Two factors underpinned this constructed reality. First and as noted above, a significant proportion of the nurse educator role is undertaken out of the clinical work unit and is thus unseen. Most nurse educators support multiple work units over the period of an eight or ten hour shift while nursing care is provided over a series of shifts and visibility of nurse educator activities may not align with the work hours of nurse clinicians. Second, the educator role may not be perceived as important as direct patient care. As evidenced by the following quote, there was a lack of appreciation of the complexity of the nurse educator role:

> Everyone wants a piece of you. I didn't realise the hours required or the diversity of the knowledge base I needed … I'm only just beginning to appreciate the full extent of the role and workload. I feel pulled from pillar to post … They can't identify what we do but would be unhappy if we weren't there. IDI NE 1 (12). L 133 / 239 / 253 / 258.

One dimension of the educator role is ensuring continuity and coherency in this area of work. It has been found elsewhere (Donner et al., 2005; Neese, 2003; Siler & Kliener, 2001) that while experienced nurse educators are expected to precept and mentor new nurse educators, these activities are not routinely identified as part of workloads and in terms of outcomes. As such, it may be difficult for staff to sustain consistency. Line manager and nurse educator participants indicated that if neophyte nurse educators were not effectively transitioned into the position, they may never fully appreciate the role and would focus only on what they think the position should be. Hence, they may function according to the perceptions of others who have no clear idea thereby reducing nurse education credibility and effectiveness (Donner et al., 2005; Neese, 2003; Siler & Kliener, 2001).

Differences between models of education and support processes across facilities made it more difficult to define the nurse educator position. This added to misperceptions of role application and achievements. A nurse educator explained:

> I report to a non-nurse line manager who does not really understand the role … I don't think they know what it is like to be a nurse educator. I feel that unfortunately for them it is a visual thing. They have to see that you. I think they appreciate the fact that you work on the floor with people but they don't realise what has to go on behind. IDI NE 1 (14). L 81 / 84 / 484.

And further:

> In rural roles they are often expected to be everything to everyone and cover diverse areas in which they may not have expertise. Sometimes I think there is too much diversity and they are asked to do too much. Also there is not always equity between roles. IDI LM 1 (10). L 39.

A review of Queensland Health (2007c, 2008a, 2010a) documents also revealed marked disparities in nurse educator job descriptions, key skills and responsibilities. In seeking to address some of these issues local strategies were instituted including the introduction of a Clinical Nurse Clinical Facilitator (RN/EN Support) position aligned to each work unit to work in collaboration with a nurse educator.

The result, however, was a blurring between nurse educator and clinical nurse/clinical facilitator positions where the latter role had been implemented. Blurring of work boundaries and associated role creep gave rise to problems in

discriminating between role responsibilities in work units/facilities. Relationships, although collegial, varied in effectiveness and confusion and some conflict over role boundaries was noted. Participants reported role ambiguity, de-valuing of the nurse educator position and instances of poor productivity among nurse educators and clinical nurse /clinical facilitator (RN/EN Support) positions. One line manager stated:

> There is some confusion. The Clinical Nurse/Clinical Facilitator position should only be operational with a focus on upskilling and mandatory skills. Nurse educators should work from a more strategic perspective with a good understanding of where the organisation is going and how they can enable that…Nurse educators need clarity in their role. Clinical nurse facilitators don't have the same knowledge and scope as nurse educators. IDI LM 1 (11). L 55 / 53.

Ambiguity surrounding the roles is reflected in the Conway and Elwin (2007) finding that comparisons of nurse educator roles in Australia are difficult when the title is used generically to explain any role that involves teaching and learning. Inconsistency in nomenclature, in turn, leads to misunderstanding where the term nurse educator is used regardless of conceptual differences over responsibilities and outcomes (Conway & Elwin, 2007; Hughes, 2005; Mackay, 1998; Mateo et al., 1998; Raja-Jones, 2002; Sayers, DiGiacomo & Davidson 2011; Squires, 1999). Related issues noted were confusion, role ambiguity and poor productivity among affected groups (Conway & Elwin, 2007; Hughes, 2005; Mackay, 1998; Mateo et al., 1998; Raja-Jones, 2002; Sayers, DiGiacomo & Davidson 2011; Squires, 1999). The two Australian studies (Conway & Elwin 2007; Sayers & DiGiacomo 2010; Sayers et al., 2011) argued that identity confusion can be explained by disparate attributes and lack of role clarity of the nurse educator and clinical nurse educator positions.

Although the position is not award-recognised in Queensland, the core attributes and responsibilities of the clinical nurse/clinical facilitator (RN/EN Support) and clinical nurse educator position, as determined by Conway and Elwin (2007, p. 191), obviously overlapped. Participants in the current research affirmed role blurring and that further consideration of the clinical nurse/clinical facilitator (RN/EN Support) position was needed.

> We should clarify the differences between the nurse educator and clinical nurse clinical facilitator roles to minimise role blurring. The nurse educators should support the clinical nurse clinical facilitator. The nurse educators problem solve and should guide and direct the new clinical nurse clinical facilitator role. However this isn't always the case and there is some degree of role confusion between the two. IDI LM 1 (10). L 18 / 45.

> If the model was working effectively it is a good model. The nurse educator should look at the more strategic picture, workforce redesign, models of care and be an infrastructure support role. The clinical nurse clinical facilitator should be doing a registered nurse enrolled nurse support role, doing the operational support, hands on, mandatory skills and then liaising more I suppose concertedly or more in depth with the nurse educator. IDI CN 1 (8). L 106.

The nurse educators sought clarity by questioning the functioning and responsibilities of the clinical nurse/clinical facilitator (RN/EN Support). Somewhat similarly, the clinical nurse/clinical facilitators (RN/EN Support) tended to compete with nurse educators for recognition and legitimation of their position. The consequence was the relative exclusion of the nurse educator from work units which had the effect of diminishing the nurse educator role. It was as though, with the insertion of the clinical nurse/clinical facilitator (RN/EN Support) position, nurse educators faced a further level of negotiation over their role. Hence, while the new position was implemented to reduce nurse educator workload the result was arguably an increase in nurse educator workload and further distortion of expectations. Two clinical nurses explained:

> They are always asking the clinical facilitators if they are organising how modules are going and how you know who the new grads are. So they are sort of the prompt in making sure the clinical facilitator is doing her role correctly and that the staff get time off line and for their modules and that the clinical nurse facilitator is supporting the process and that processes are being implemented and standards are being met. Sometimes it is difficult to achieve especially when I am busy supporting new starters. IDI CN 1 (9). L 256.

> There is frustration (over) the difference between the Clinical Facilitator role and the educator role and where you can sort of integrate them (to) support each other and make the best combination. IDI CN 1 (5). L 12.

Nonetheless, the clinical nurse/clinical facilitator (RN/EN Support) position was also perceived as valuable because it allowed the nurse educator to focus on more strategic activities and addressed some concerns about nurse educator visibility. A nurse unit manager explains:

> I use the clinical facilitator to cover work that used to be done by the educator as this role gives the work unit one person in their own environment that they can go to. My clinical facilitator works closer with me than the nurse educator. IDI NUM 2 (10). L 203 / 207.

It was also the case that views on the nurse educator role were primarily drawn from interactions with individual educators rather than the collective or job descriptions. The personality traits of the educators shaped the meanings that participants attributed to the position. The following quotes reflect the ways in which the nurse educator role was conceived:

> It depends on the personality of the educator. If they use their personality in a therapeutic way they build trust with the staff, they get to know the staff members, they know what is happening. IDI CN 1 (1). L 256.

> I think it really depends on the person in the role. I have seen some excellent nurse educators about and I've had a lot of contact with them and feel very supported by them but I have seen other areas where you kind of do wonder what actually goes on and how they contribute to education. IDI CN 1 (8). L 53.

While the nurse educator participants, and line manager participants who had been nurse educators, were able to express more in-depth insight into the attributes and responsibilities of the nurse educator there was a distinct lack of awareness across the other groups of the comprehensive nature of the position. There existed, however, clear views about visible characteristics of the educator.

4.2.2 Managing Expectations

There are so many competing expectations

The sub-category *managing expectations* depicts the expectations of the hospital employed nurse educator and how these shaped the actions of the educators in workplace learning. A view expressed by line managers and nurse educators was that while there appeared to be nothing amiss with the nurse educator role there was much variation between stakeholder expectations. Thus, even though nurse educators adjusted their behaviours and actions to those of others, a sense of balance was not achieved as there were was no joint meaning. There were also unrealistic beliefs and vested interests.

It was expected that nurse educators would take a key role and be visible in the workplace when supporting the continuing development of nursing staff. Furthermore, nurse educators would maintain standards at the point of practice including facilitating safe competent care, promoting inquiry, challenging staff to reflect on practice and applying evidence in practice. It was also understood that nurse educators would be knowledgeable, passionate and fully engaged in all facets of the position. This required the educators to socially interact with colleagues at all levels and to fit their actions with those of others who may not necessarily act in the same manner or respond as expected.

Although the educator participated in professional and social activities in work units it was difficult for them to penetrate the culture and they were constructed as outsiders by all participant groups. The educators generally provided educational support across a number of work units and as such were not identified in work unit profiles as staff members and nor were they viewed in the same manner as nurse unit managers. Thus the unspoken and unwritten information essential to function as a team member in clinical areas was often denied this group. The nurse unit manager was viewed as the clinical leader who had control of the work unit budget and thus held the balance of power. As an outsider nurse educator work was marginalised and arbitrated by the power and territorial behaviour of others. It was noted that nurse unit managers made concerted efforts to supervise nurse educators and that clinical nurse/clinical facilitators (RN/EN Support) competed with the educators over the dimensions of the role.

> I see that as my nurse educator she should be here when I need her. I regularly ring her to come to the work in the unit when we are busy so she can help the staff and she doesn't always respond… I need her on the floor. IDI LM 1 (10). L 185.

> They are not in the ward all the time so my nurse unit manager relies on me. I think there is some confusion over the role but they have three wards and the staff in my ward see me as clinically credible and I work with the new graduates. IDI CN 1 (4). L 169 / 170.

As noted nurse unit managers oversaw nurse educator work unit interactions particularly in relation to the ways in which the role was enacted and the degree of nurse educator visibility. Where there was incongruity between the expectations of the two groups the managers expressed frustration over the nature of support provided by the educators.

Consistently high expectations of the nurse educator were expressed across the groups in this research. A review revealed no empirical literature, either national or international, against which to compare these expectations. The literature is sparse, with a paucity of analysis of the role of nurse educators in positions similar to those in this research (Sayers, DiGiacomo & Davidson 2011; Squires, 1999). Participant expectations aligned superficially with draft activities and responsibility domains attributed to nurse specialist professional development (American Nurses Association, 2008; Mathews, 2009). However, as it is unclear whether the draft domains have been applied consistently, validated or evaluated, remains uncertain if they represent realistic expectations. Participants did not highlight any frameworks such as the ANTS Competency Standards (ANTS, 2010; Guy et al., 2011). No literature addressing role overload or role expectations of the public-sector nurse educator role was located.

4.2.2.1 Line Manager Expectations

Strategic and resource support is important

The line manager of a nurse educator retained the overarching responsibility for guiding and directing nurse educator activities and measuring outcomes achieved. As managers, they also assumed responsibility for how the nurse educator role was positioned in the organisation. However, it was noted that the model of nursing education and professional preparation and expertise of this group varied considerably.

Generally line managers expected nurse educators to demonstrate a good appreciation of several factors: nursing, standards of practice, the profession and the complexity of the contemporary health care environment. These were expected to be assimilated into an understanding of the implications for work practices and how

they should be presented as a role model. They were also portrayed as leaders in clinical practice with an ability to intellectualise and contextualise practice, to align scope of practice and professional requirements within a work context and to implement change. Yet ultimately, line managers constructed nurse educators as a safety net resource for staff. Two line managers explained:

> People want to feel safe and supported at work and that means they are not going to fall foul of an incident or event. They want people such as educators to guide and mentor them. That's what safe and supported actually means. You are dealing with their emotional being and their spiritual being and their emotional intelligence or lack of intelligence. IDI LM 1 (7). L 192.

> They make a major contribution in almost an intellectual sense associated with maintaining standards so the profession…you know … can engage in things like the scope of practice issues, professional boundaries, procedures and policies and the other things that establish standards. Yes a major contribution in standard maintenance for the nursing profession and perhaps even pushing the boundaries of standards. IDI LM 1 (1). L 121.

Line managers expected nurse educators to have a helicopter view across broad issues. Expectations extended to an ability to comprehend the strategic intent of health care, the profession and the organisation, as well as 'step up' and 'trouble shoot' to minimise risks to the organisation, staff and patients. If nurse educators were to function effectively as a safety net education resource, line managers could rely on them to provide advice about change requirements, innovations and remediation strategies before issues get out of hand. An underlying premise was that nurse educators should be advising the line manager and 'if not, why not?' Thus line managers relied on the nurse educators as professional advocates and change agents in a facility or service area. A lack of line manager educational expertise, and or time would further reinforce this broad professional role expectation of the nurse educator. Additionally, being viewed as an outsider gave some legitimacy to demands that educators work across unit boundaries and provide advice to line managers on education, cultural, workforce and management activities.

Hence, nurse educators were seen to have both strategic and operational role characteristics: to be leaders guiding and supporting clinical, organisational and professional practice while responding to workplace issues around staff capacity to provide care and ensure patient safety. The complexity of the role and variations in

expectations were not noted in this research. Perceptions of role characteristics were based on needs at a given time and within a specific context. The experience was described by a line manager:

> As a manager and nursing leader having the nurse educators as a resource available to me enables me to do my job and manage standards of care in the area. The job is hard enough (and) if I didn't have them as resources my job would be even harder because I would be doing it myself. I expect them to be across a whole spectrum of areas involved in what is happening on a statewide basis and in hospital and district services. I expect them to be engaged in professional processes that function in that space so they are not isolated in their own practice and I expect them to inform colleagues and me and become drivers of those processes instead of me driving them. IDI LM 1 (7). L 108 / 117 / 133 / 137.

It appeared that overall the nurse educator was viewed as a professional conduit that reduced the workloads of line managers by coordinating strategic and managerial initiatives.

The meanings conveyed here are supported by Challis (2001), Shanley (2004) and McCormack and Slater (2006), who contend that nurse managers and nurse educators should work in partnership with nurse educators acting as a 'go between' and advising others on education needs, infrastructure and resources. Yet the concept of partnership implies equal input into role definition. In this research, expectations were defined by both the line managers and nurse unit managers and these did not necessarily align. The result was confusion and a sense of disconnect for the nurse educator. Furthermore, the nurse educator may struggle to simultaneously deal with education priorities and line manager expectations on strategic change, as well as attending to the interests and varying expectations of staff within multiple work units. An over emphasis on the interests of line managers could lead to disgruntled work unit staff and may constrain the capacity of the nurse educator to gain support for core education activities.

How the nurse educator position was situated within work units varied with reports that they were not fully capitalised. Line managers expressed the view that nurse educators should be involved in recruitment and selection activities, role modeling and leadership in fostering practice based on standards and evidence. This involvement was seen as integral in stabilising the environment and encouraging

staff to review and reflect rather than reduce practice to tasks. It was generally claimed by line manager participants that the workforce was becoming less skilled due to international shortages of registered nurses. As one line manager noted:

> With all the new starters and increasing numbers of casual staff the nurse educators are even more valuable as they provide extra support and keep track of milestone development … standards of practice and evidence based practice and assist with strategies to address mistakes and staff performance. IDI LM 1 (12). L 68.

Given views expressed in respect to the changing nature of the nursing workforce and reduction in skills there was considerable line manager agreement that capacity building and resource support should be provided in the workplace by a specialist position such as a nurse educator. It was also acknowledged that nurse educators should not be embroiled in operational work such as having a daily clinical patient allocation. Furthermore, interpretations were it would be difficult to maintain safe patient outcomes if there were no nurse educators as most staff, for a range of reasons, may not engage fully the tenets of the professional nurse. One clinical nurse explained that:

> There are staff shortages and people are being promoted a lot earlier. We have a lot of inexperienced people in higher positions because there is no one else. I think we have an uncoordinated rabble in wards many who just want to come to work and go home. They really are not very professional or have interest in their own development. I believe they would turn into navvies without the nurse educators to support them and assist maintain standards. IDI CN 1 (1). L 68 / 74 / 82.

While it was considered appropriate that the nurse educator position should function outside the constraints of a work unit or clinical workload, this contrasted with the views of others that the nurse educator needed to be ‘on the floor’, ‘on tap’ and visible. Hence there was a disparity in meaning over role engagement and the extent of visibility required in work units.

An example was the expectation of line managers that nurse educators should be able to scan and interpret the environment and industry and make modifications to education initiatives to accommodate changing service and practice demands. The capacity of a nurse educator to have a broad outlook was seen as essential in encouraging work units to consider alternative work processes. An ability to link organisational and professional requirements to work units, in terms

that staff could understand and apply to practice, was also a desired attribute. The line managers further noted that nurse educators fulfilled a role that supported change and assisted staff in work units to develop so that they had the capacity to provide safe and competent patient care. They expected them to achieve this by being cognisant of clinical, profession and organisational learning needs. Line managers also expected nurse educators to contextualise these processes to suit specific differences and needs. This was despite the fact that the educators functioned across health service districts, or facilities, or numerous clinical work units.

In contrast to the above, the nurse educators expressed frustration about non-inclusion in strategic management and decision-making (such as service re-design) and lack of role respect and acceptance. This was attributed to their hidden role or work and perceptions of lack of visibility and being situated as the other in work units. Indeed, they were often considered insignificant and were disregarded and dismissed as whinging and typically finding excuses for not being in work units. However, because they were in a public role and concerned about how others view them they looked to self-perseveration and accommodation strategies. The following nurse explained that:

> The nurse educators understand how the industry works and the context of practice; but struggle to meet staff expectations and to keep abreast of constant change and demands. They aren't always available as they do other things so we make decisions and I ask the educator when I see her to help make the change or work with the staff. I know she likes to be included but she isn't always around. IDI NUM 1 (3). L 260.

In practice, therefore, what was required of the educators was an interpretation of line manager nurse unit manager expectations and of disparities between work unit practices and developmental needs. Furthermore, there was much room for a divergence of interpretations of the educator role in the complexity of the work situation and this confounded perceptions of educator effectiveness. One line manager noted:

> We need nurse educators because we have such a large workforce with many levels/grades. They support skill development and assist in supporting the development of the tenets of the profession. Alternatively they assist in stopping nursing being reduced to a set of tasks by facilitating critical thinking and problem solving skills and facilitating a culture of learning. However not all are as supportive in work units as

> mine. In relation to standards they provide a safety net. They should also provide a support system to work units and nurse unit managers. IDI LM 1 (11). L 38.

The safety net concept is significant where the educators were constructed as an extension of the line manager role. Here the nurse educator was positioned to assume responsibilities of the line manager role through activities that would not be fulfilled without nurse educator involvement. These included reducing work place risks, supporting practice standards, quality projects and guiding remediation associated with performance appraisal and development. A line manager described their understanding of support process:

> The nurse educators make significant contributions in every facet of nursing practice for example career development, succession planning, scope of practice and advancing practice, workshops, professional standards, competencies, policies and in providing checks and balances. They are involved in projects that impact on practice e.g. falls. They have some good systems in place such as action and service delivery plans plus data collection methods. They also participate in clinical audits and apply outcomes to programs and risk mitigation strategies. IDI LM 1 (10). L 66 / 68 / 82 / 146.

However, while line managers referred to the nurse educator as an integral strategic resource this was as a safety net and 'trouble shooter' who was able to minimise risks to patients, staff, the organisation and ultimately the line manager. As an extension of the line manager role some expectations contributed to the perceived invisibility of the nurse educator. If the nurse educator is viewed only as a go between advising on education needs, infrastructure and resources, this sets them apart from others and potentially adds to lack of appreciation and increased tension in work units.

What was determined therefore was that where the line managers gave support to the educator role and emphasised its importance this invariably was posed in terms of the ways in which the educator conformed to their interests. Line managers are in positions of power but in this research it was unclear how they used this power to reinforce and espouse the nurse educator role in a facility. What was clear was that line manager expectations differed from those expressed by nurse unit managers and clinical nurses. While the former group acknowledged the strategic and resource value of the nurse educator role others viewed it from a much more

operational perspective. This undermined the effectiveness of communication necessary for a nurse educator to meet line manager expectations, particularly where the educator did not share a line manager with the relevant nurse unit manager.

4.2.2.2 Nurse Unit Manager Expectations

They need to make the role their own

Predictably the nurse managers had a stronger operational and unit focus than the line managers or nurse educators. This group wanted the nurse educator to be self-initiating and to provide educational support and advice to all staff in line with the core business of the unit. This meant that nurse educators needed to understand the culture and boundaries of each work unit and to adapt their actions and interactions in constructing a culture of learning. Developing a sense of belonging was the responsibility of the nurse educator. Yet the nurse educator could not achieve in isolation and needed transparency in what was required and what the requirements meant if services were to meet learning needs.

Further, the nurse unit manager group expected the nurse educator to support practice standards, set up systems, build capacity and develop strategic direction. A nurse unit manager explained that:

> Nurse educators are essential as they understand the industry and the environment in which they work and then contextualise programs, skills, communication and leadership to adapt to the needs of both the organisation and profession while supporting the core business of providing safe care. IDI NUM 1 (10). L 56.

Engagement and effective communication between the nurse unit manager and nurse educator were identified as part of the role and the educator was expected to take the lead role in coordinating and monitoring nursing education activities. For some nurse unit managers this was one less activity that they, the manager, need be responsible for and in most cases they were well supported by nurse educators in this endeavour. A participant explains:

> I think an educator plays a vital role in respect to being a resource person and supporting nurses to advance their practice and be interested in education and research. As a manager I need an educator who is able to do that and be a liaison person who is able to help in terms of resources, programs and running programs. They need to be engaged and make the role their own rather than sit back and watch. IDI NUM 1 (1). L 11 / 97.

In situations where nurse unit managers perceived that they were not well supported (e.g. a nurse educator was not providing services to the standard expected by the nurse unit manager or lacking visibility) they looked for, and in most instances found, alternatives such as ramping or modifying the clinical nurse facilitator role. These substitute staff undertook extra education and support responsibilities and looked to their line managers and others to assist in addressing issues. Two nurse managers described their experience:

> It's an extremely valuable role and certainly makes my life as a nurse unit manager personally and organisationally much easier. I feel that a lot of the whole area of staff development and training I can delegate to the clinical teachers knowing the educator has overseen it and will manage what is required. IDI NUM 1 (3). L 438.

> Most of the people in my unit actually deal with the clinical facilitator although they are aware who the educator is. I have found that staff knowledge of the nurse educator depends squarely on the individual educator. IDI NUM 1 (7). L 31 / 39.

Here again the perception was that the nurse educator existed as a support to the nurse unit manager and thus could be delegated activities to the extent that one nurse unit manager referred to an educator 'as my wing man'. The unit managers made a concerted effort to supervise the nurse educator who was generally seen as an outside resource who should be available to act as the nurse unit manager deemed appropriate. The concept of power is related to the perception of self in relation to another and therefore as perceptions vary so will the nature of relationships formed in the workplace (Salin, 2003; Zapf & Einarsen, 2003). Thus nurse managers tended to judge the work of nurse educators in terms of how they perceived the importance of their own role. This group self-defined as the main protagonists in wanting the nurse educator on the floor, filling in, or being available to take a direct patient workload. For example, nurse educators sometimes undertook direct care in situations of increased unit workloads and emergency leave. Indeed, an effective nurse educator was described as one whose views and actions were closely aligned to those of the nurse unit manager. This led to feelings of nurse educator frustration and humiliation that as equals they were obliged to account for their time and activities and to make concessions to be on the floor to fulfill others' expectations. That the nurse educator was to be visible and available on demand meant that this role was perceived as an additional resource, not only for the line manager but for

the nurse unit manager. The educator role therefore assumed a remarkable flexibility.

Flexibility as a defining feature was engendered in the view that educators were not as busy as others because they were not managing wards and so had excess time. This was because educators were viewed as unburdened by either line manager responsibilities or a direct clinical workload. The nurse educator existed as an operational resource to be available on demand to assist in mitigating work unit risks and at the discretion of the nurse unit manager. Nurse unit managers described their expectations as follows:

> It really depends on what it is. I mean there have been a couple days when I've actually phoned my nurse educator and said to her 'if you don't have much on, would you mind just coming on the floor'. I may have 50–60 % casual agency or casuals and three new graduates on. Then it's about very much working one on one and providing care to achieve safe standards of practice for safety for my patients and the ward but support to me. Her support is invaluable to the staff on the floor. IDI NUM 1 (7). L 187 /191.

> I need the nurse educator to be available on the ward and be there the majority of the time as things happen all of a sudden so they should there to keep the group up to speed as there is such a vast scope and vast amount of things that we do every day. They are sometimes responsible for everything that no one else wants. IDI NUM 1 (6). L 176 / 200 / 204.

Yet some nurse unit managers perceived nurse educators as *their* associates or people employed at the same classification who they could trust. The educators were considered to generally give impartial advice, support and leadership to both the nurse unit manager and staff in the work unit. Someone of a similar standing professionally was seen as helpful. This reinforced a situation where the nurse educator was expected to act differently within different contexts to conform to nurse unit manager expectations. This created tension when the nurse educator was unable to determine what was required in a given situation and attempted to work from the perspective of a trusted associate. Thus nurse unit managers saw collaboration while nurse educators saw adaptation. Two nurse unit managers explained that:

> It's an excellent relationship (and) one of the particularly positive things for me about the relationship is that it's someone that I can talk to. The individual in the role has provided some mentoring in terms of my succession planning to the nurse unit manager role. It's someone who is

> linked to the program (i.e. work unit) but also sits a little outside some of the politics. IDI NUM 1 (3). L 122.

> We are both essentially managers but from different perspectives. I see my role with my educator as a collaborative on a lot of issues. It's consultative and it's good to get somebody else's perspective and bounce ideas. She's actually a support to me…So there is a degree of collaboration and we both encourage the culture, standards and ongoing professional development for our staff. IDI NUM 1 (7). L 43 / 167.

It appears from the above that relationships between nurse unit managers and nurse educators were characterised by a power struggle over implementation of education services where the educator was most often in a losing position. As one nurse educator put it:

> I think the bottom line of my role is to support the nurse unit manager… If I don't maintain a positive relationship I have trouble having staff released for education. IDI NE 1 (11). L 12.

The nurse educator position had value but perceptions of that value varied depending on relationships formed, the visibility and engagement of the nurse educator, and how nurse educator activities conformed to the clinical priorities of the work unit. Expectations of nurse managers are linked inherently to the other category identified in this research, *constructing workplace learning*.

4.2.2.3 Clinical Nurse Expectations

Impartial support

The clinical nurse group converged with the other three groups on expectations; however these were expressed in individual terms such as visibility, leadership, being knowledgeable, and credibility. Hence the emphasis was largely on personal characteristics rather than the role. Clinical nurses had little insight into the hidden work of the nurse educator and referred to tasks rather than the over-arching elements and attributes of the position. As two clinical nurses explained:

> They need to support people who are, who have questions to ask then who are investigating practice. They need to support the new people coming in who need to learn the role and make sure that they maintain standards… they should support me when I need it. IDI CN 1 (1). L 200 / 208.

> You expect your nurse to be someone who has a lot of knowledge that you can call on with just about anything. I think people sometimes get disappointed when their expectations aren't met. IDI CN 1 (3). L 56 / 60.

As noted above, the responsibilities and attributes of nurse educators and clinical nurse clinical/facilitators (RN/EN Support) were blurred. For example, nurses who had acted in nurse educator positions saw the clinical/nurse clinical facilitator (RN/EN Support) and the nurse educator as the same until they had worked in both positions. One clinical nurse noted that:

> There is a bit of confusion I think in that clinical facilitator /teacher has a bit of an education role as well similar to the nurse educator. So there is confusion as people are not sure who's doing what. The educator oversees everything to do with education the clinical teacher does specific bits of work but people get confused where this stops. IDI CN 1 (10). L 52 / 56.

Confusion was expressed about role meaning and relationships between nurse educators and clinical nurse/ clinical nurse facilitators. The clinical nurse group also perceived the nurse educator role to be of less value than that of other roles.

However, this group also judged nurse educators as impartial actors within the hierarchy and thus people to approach as alternatives to nurse unit managers. Two clinical nurses explained their experiences noting that:

> They are the people you expect to drive the cause and the ones … who give you the motivation to keep going when things get tough … for whatever reason, they never sort of feel apathetic or it's hopeless, they just sort of stay positive and attempt to assist others to stay motivated … They are not your line manager sort of thing they come in and out and view things and provide support independently which is very important. IDI CN 1 (4). L 168 / 172 / 343.

> Because the nurse educators are working in the environment even though they are impartial they also tend to be involved and know what's going and can make informed decisions based on that not just decisions based on theory. IDI CN 1 (3). L 272 / 273.

Even though the clinical nurse groups had little experience of the full dimensions of nurse educator work they nonetheless also referred to the role as a valuable safety net resource. However, although the educator role was viewed as supportive it was blurred with that of clinical/nurse clinical facilitator (RN/EN Support) and perceived to be of less value than, for example, the nurse unit manager role.

4.2.2.4 Nurse Educator Expectations

We provide a safety net

Ideally nurse educators sought to construct an educational environment that addressed teaching and learning needs and to foster social interaction to enable a shared understanding of practice expectations. Their actions supported teaching and learning needs and provided ongoing support for, particularly, inexperienced staff who may be hesitant in working in high acuity environments with high patient turn-over, without safety net support, and knowing their scope of practice. They took a lead role in upskilling staff and supporting safe practice standards from a clinical, professional and organisational perspective, as well as assisting staff to proactively address fears related to roles, practice and service expectations. For the educators, a collaborative and collegial relationship with nurse unit managers was imperative to effective education services. However, they experienced a lack of appreciation of the complexity of the role. Two nurse educators commented:

> We provide a safety net' to the staff. We are there to help and guide staff and assist them to practice safely … especially the new starters and graduates. IDI NE 1 (10). L 82.

> The nurse educator has a big role to play in helping the floor staff and assisting them to appreciate what is required and assisting them to achieve and appreciate the whole environment and what are all the elements of their role thereby assisting them to become more confident and mature. IDI NE 1 (9). L 268 / 272.

According to the educators, a major part of their role was to engender within colleagues an appreciation for the ongoing nature of learning. The group perceived, however, that it was difficult to measure the impact of their contribution particularly as measurement was reliant on perceptions and not reality. It appeared impossible to determine the basis of nurse educator effectiveness. This was viewed important as nurse educators do not routinely provide direct patient care which, in the current political climate, is considered to be the main measurement of worth and return on investment of employment. McCormack and Slater (2006) attempted to determine the contribution of UK clinical education facilitators and reported difficulty in measuring the extent of support/contribution. Contributions to practice and standards made by nurse educators are noted as follows:

> 100% of the nurse educator role does contribute in some way to clinical practice and the subsequent development of staff. What we do as nurse educators is that we are able to identify the gaps between current practice and evidenced based practice. When safety and quality risk management issues, when risks or quality issues come to light we are able to address by teaching or change management and assist in improving the quality of service that we provide to the patients. IDI NE 1 (4). L 171 / 175.

> Of course nurse educators contribute to clinical practice and continuing development. Absolutely I mean nurse educators plan we try to be proactive, we look at trends and we look at standards but we also respond to specific needs. We also contribute by working with people, by networking and through providing programs to address trends and practice gaps. IDI NE 1 (15). L 210.

Perhaps unsurprisingly, nurse educators viewed their role as integral to the core business of health; however, the frustration and concern that characterised this group was related to lack of support for nurse educators, particularly those new in the role, and changing stakeholder expectations of their role.

Expectations of support for novice nurse educators were similar to those identified for any other staff members undergoing transition to a new position. Hence, an understanding that identity is socially constructed is important as both a core sense of self and collective sense of one as a nurse educator should reduce differences and facilitate shared meanings as nurse educators (Hewitt, 2007). This understanding provides the new nurse educator with a sense of who and what fits in and outside the boundaries of the nurse educator role. This is consistent with Blumer's (1969) principle that meaning is central to behaviour and is based on what one believes to be true.

Nonetheless, novice nurse educators learned the role largely through osmosis while often working in a clinical role one week and a nurse educator role the next. Experienced nurse educators were responsible for helping them to gain confidence and competency in the position often without the aid of a formal orientation program and while fulfilling their own workloads. In the chain of safety nets the experienced nurse educator acts as a necessary net for novice educators who are expected to be a fully functioning resource for work units from day one in the role. The perception

was that not all new nurse educators were adequately orientated or supported which meant that some did not develop a sound appreciation of the role. One nurse educator explained:

> I don't think they have any idea about the role, very little idea I know that when I started I didn't but I'm starting to. It's getting better in terms of being proactive but a big part is reactive. I was initially overwhelmed but had to be available to help others and just try to do the best I could. Staff just expected me to know what to do which was rather intimidating. Other educators helped and provided guidance but they had their own work and were not always in the wards with me. IDI NE 1 (12). L 96 / 113.

Research by Challis (2001), Siler and Kliener (2001) and Neese (2003) generated similar results in finding that new nurse educators are not normally well supported and are expected to learn the key elements of the role as they work, often with little orientation and support. Furthermore, these authors maintain that new nurse educators impose a burden on experienced educators who, in addition to their own workload, need both to teach the new nurse educator how to teach, and to carry some additional workload themselves until the new educators gain confidence and experience.

Nurse educators are seen as integral infrastructure support in facilities and seek to reduce perceptions that nursing work can be reduced to a set of skills and in the absence of thinking, problem-solving essentials. Nonetheless, the nurse educators were constantly responding to the expectations of others. When the identity of a nurse educator, or the collective boundaries of the nurse educator group, do not align with the cultural environment of others shared meanings are not achieved. This resonates with Blumer's (1969) argument that meaning is derived from social interaction and this constitutes social reality and influences actions. As such, being unclear about what is expected reinforced difference and uncertainty. Lack of insight into the complexity of the role was because the educators existed as an overarching support service that frequently relied on the expectations and goodwill of others to achieve service outcomes. Not always being part of work unit decisions, or a cohesive work unit group culture, caused frustration. It was also important not to upset nurse unit managers in daily interactions as this would

damage working relationships. The following excerpts reflect the views of nurse educators:

> Obviously you're involved in role development and things like getting other staff through that succession planning, mentoring, and a preceptorship role. You need to respond to organisation concerns like you know when they do the rostering reengineering all that sort of thing, the organisational needs. And you need to think about you know what kind of strategies or innovations you can actually lend to the mix so that you're assisting in making sure that you've got that educational focus and that you've got efficient resource utilisation. IDI NE 1 (18). L 79.

> It is difficult to be proactive when expectations keep changing … a big part is reactive … it is frustrating because if you're reacting you've already got things in your diary, commitments, so it is often difficult. IDI NE 1 (12). L 96 / 104.

Nurse educators voiced frustration about changing expectations of key stakeholders. For example, work units requested training that was not then supported by staff release and the extent of nurse educator inclusion in work unit service delivery changes varied. Thus the nurse educator's ability to plan and achieve outcomes, build relationships, and develop a feeling of value was often hindered. According to the nurse educator participants, where they experienced frustration and/or were unable to meet expectations, they tended to withdraw themselves and/or services. This strategy had the potential to further negatively impact on perceptions of role achievement, visibility, team interaction and engagement.

4.3 Conclusion

It has been argued in this chapter that individuals act in both cooperation and competition with others in jointly defining roles (Mead, 1934). That is, humans learn what to expect from others through role taking and the process of anticipating responses from others with whom they interact. To bring this point to the research context, role taking assumes that an individual will fulfill a role required by an employer (Katz & Kahn, 1978) and that employees will be required to enact a range of roles. This may be problematic if the complexity results in the employee being unable to fulfill role responsibilities as expected by others.

From this premise the chapter explored the differing views on the expectations of the hospital employed nurse educator role within the context of nurse education services. The prevailing view was that the educator position was highly valued. However, while reference was made to skills including capacity building, fostering of inquiry, and support for practice standards, the role of educator was fundamentally viewed as a safety net. How value was conceived therefore was shaped, not by the full extent and nature of the nurse educator role, but by its contextual meaning. Importantly, the absence of an acknowledgement of the complexity of the position did not diminish the expectations of the line managers, nurse unit managers and clinical nurse participants that nurse educators should be all things to all people. Yet this perception reinforced the view that the hospital employed nurse educator position was multifaceted, difficult to describe, poorly understood and not measurable in terms of outcomes.

This research reinforces the assertion of Conway and Elwin (2007) and Sayers and DiGiacomo (2010) that the role of the hospital employed nurse educator in Australia is unclear, varied, complex and poorly understood. There exists role blurring, erosion, confusing nomenclature, and variation in professional relationships. A devaluing of the role also impacts negatively on nurse educator role enactment, job satisfaction and retention (Foster, 2005; Queensland Health, 2010a).

From a symbolic interactionist perspective a discrepancy in meaning meant a breakdown of sense making and of joint action (Blumer, 1969). Hence, there appeared symbolic boundaries that both reflected and reinforced the complexities surrounding the nurse educator role. These boundaries constrained the capacity of nurse educators to construct favourable contexts for workplace learning. Irrespective of constraints, in this research nurse educators were regarded as undertaking an essential role in generating a culture of learning within the workplace through establishing strong workplace identify, visibility and engagement in practice context. The category *constructing workplace learning* and its sub-categories *engendering a learning culture, and struggling for an identity* are the focus of the following chapter.

CHAPTER 5 – CONSTRUCTING WORKPLACE LEARNING

5.1 Introduction

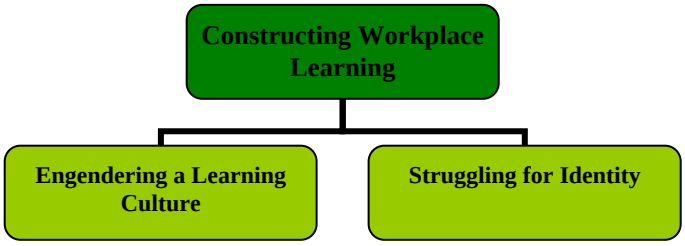
In this chapter an exploration of the category, *constructing workplace learning,* provides insight into the location of the nurse educator within workplace learning processes in the research context. The chapter begins with perceptions of the role and positioning of the nurse educator in this research and follows with an examination of structural factors and tensions that shaped the capacity of the nurse educator to cultivate a learning culture.

5.2 Constructing Workplace Learning

The category, *constructing workplace learning,* reflects participant perceptions around educational focus, requirements and processes applied in workplace learning. The emphasis of this chapter is on how the identity of the nurse educator as the key actor in facilitating a workplace learning culture was established through engagement and visibility and the expectations of others. Participant and group interpretations are explored within the context of the perceived capacity of nurse educators to advance a culture that espouses and resources workplace learning. While such learning was considered essential for capacity building and the provision of competent nursing care, support was not necessarily a feature within a culture where clinical care took precedence. Despite adhering to sound principles of learning nurse educators confronted organisational, professional and interpersonal barriers in constructing workplace learning.

Figure 5.1: Category – Constructing Workplace Learning

The old days are gone



The unambiguous view of the participants was that learning was central to sustaining nursing standards. This aligns with Billett's (2001) assertion that learning and working are interdependent, with learning occurring through engagement with goal-directed activities. As such, learning is dependent upon the kinds of activities that are engaged in, the access to situational factors including support and guidance, and the ways in which individuals engage, interact and construct knowledge in these situations. These factors underpin both the process of learning and what is learned in the workplace. Billett (2004) further argues that, in cultivating learning in the workplace, contingent factors need to be considered in the construction of a workplace conducive to learning. These assertions converge with understandings generated in this research around the expectation that the hospital employed nurse educator will assume a lead role in constructing workplace learning within a health facility context.

Furthermore, within the hospital setting, the nurse educator was attributed the role of principal actor in nurturing learning for nursing staff. Nonetheless, while there was organisational legitimation of the role, the symbols and resources that defined that role were subject to interpretation. Hence, as argued in the previous chapter, individuals and groups created different meanings around the activities of the nurse educator and their contribution to workplace learning. One salient reason was that organisational systems and processes were essential to the facilitation of education and the engagement in learning. Such processes were entrenched in existing systems. A line manager explains:

> The services the nurse educators offer are based on systems and processes which are embedded in clinical service delivery and support how outcomes are achieved. They develop policies and assist in setting up education process and systems that support education activities e.g. track assessments. IDI LM 1 (10). L 82.

The use of existing systems to foster engagement in staff development is consistent with the findings of other works (Challis, 2001; Gallagher, 2007; Lombard, 1990; Prosser, Trigwell & Taylor, 1994; Sayers et al., 2011; Shanley, 2004). As participants noted, because nurse educators were employed to work in health care facilities it was expected that they had a clear appreciation of the health care system and the importance of supported learning in the workplace as it existed. It was also perceived that nurse educators were best positioned to appreciate the

boundaries that existed between groups because the educators were situated as the other. It was though the educator in being positioned as outsider was necessary because it was the educator, and not the organisation that needed to demonstrate flexibility. This was posed in terms of the importance of nurse educator understanding of the context of practice. As the following notes:

> It's about the context, they just understand so well the nurses they're teaching, where they're working, and the sort of issues they will meet. So I suppose thinking of those adult, principles of adult education of what adults learn they are relating learning to what they are doing and to where they are working. The nurse educator understands the context and industry and how hospitals work. That's partly the case but I think we also have a lot of flexibility which is another strength of the nurse educator's role. There is huge flexibility in how and what is delivered in learning programs and support to the clinicians. They are not constrained by a timetable. I would like to see more nurse educators. IDI NUM 1 (3). L 252 / 266/ 274 / 278.

Indeed, the nature of the clinical environment and the life experiences of staff required the nurse educator to consider the experiences of learners and to work to develop the knowledge, skills and competencies needed in professional development. However, this often gave rise to tension because a function of the nurse educator was to challenge staff to reflect critically and to change practice and behaviours. At times staff did not see the value of the educational activity and perceived nurse educator support and workplace learning strategies as a distraction from direct patient care. A line manager noted:

> It's got to be a blend of providing the theory (and) providing some guidance by working with the person to get the best results for patient care. It needs to be based on evidence while supporting individual needs. But staff need to see the relevance otherwise they don't want to participate. This becomes a problem if they just care how they always have and don't keep up with changes in practice. IDI NUM 1 (5). L 39.

Thus the nurse educator position and its function was much more than just teaching. Learning was not to be viewed as simply an unconscious response to training, but rather to be embraced as goal-directed (Young & Patterson, 2007). Participants noted that nurse educators have in recent years attempted to shift the teaching and learning focus to the learner. Nurse educators were seen to adopt the approach, to the extent possible within organisational constraints, that learning was an active process where learners construct knowledge differently and that dialogue and experimentation are part of the nature of a learning environment. Ideally this

meant that nurse educators were very approachable because they encouraged staff to explore options and to engage with others (professionals, patients and colleagues) in the pursuit of knowledge. It thus appeared that the educators and learners were working effectively as active partners and that learning was continuous and as such needed to be self-directed. The following participant explained:

> The days of 'teaching at people' are gone…it's now about support, engaging, coordinating and managing process to assist staff hit their milestones and encourage ongoing involvement. IDI LM 1 (8). L 86.

Freire (2000), and Young and Patterson (2007) similarly contend that learning is an active process whereby the teacher considers the previous learning and experiences of the learner and together they build knowledge and skills. Gillespie (2002) also argued that willingness to share personal and professional knowledge and willingness to get to know a person will improve learner outcomes.

There was the perception therefore that nurses were accountable for their own learning and the most important stakeholders in the relationship. Yet, and while nurse educators explored different ways of understanding and worked to change ideas, they were caught between two worlds (education and clinical practice) in such a way that risked diluting their capacity to cultivate learning and undermined a sense of identity and belonging. Where the focus was on clinical activity, nurse educators negotiated the context of practice and acted as a resource to support learning and to foster a learner-centered approach. Two participants noted that:

> When teaching, providing any form of education, I work closely with the learner. I know all people are different, we all learn in different ways. That is why I would have a different approach every time based on the learner's needs. Other people acknowledge the way they learn, my teaching is learner based. … I try to have the learner consider different ways of knowing and doing. Though, this is not always successful as they like to be spoon fed. IDI NE 1 (4). L 71.

> They are definitely more involved with the staff trying to support them … The old days are gone. They are now trying to engage staff and get them to change their ways of thinking and their attitudes to education and be able to cope with ongoing changes. IDI LM 1 (9). L 254 / 370.

Although it was agreed that individual staff should be responsible for self-development and learning experiences this was not always the case given the nature of workloads and other factors such as release from clinical work and culture. One clinical nurse stated:

> Most nurses just want to just come to work do a good job and go home ... 'without nurse educators we will be turned into navvies'. IDI CN 1 (7). L 292.

These understandings are reiterated in other works (Billett, 2001, 2004; Perkins & Tishman, 1993; Munro 2008). Munro (2008) argues that employment and organisational barriers to professional development include work demands, anxiety and climate of support, while Perkins and Tishman (1993) purport that if individuals do not engage in the learning process, their learning outcomes may be weak and the learning experience de-valued. Similarly, Billett (2001) points to a number of limitations associated with workplace learning such as learning that falters because of the nature of the work and a reluctance by workers to participate and to engage with professional support.

Where nurse educators were available for collaboration and support staff mandatory skills were assessed, upskilling was encouraged and scope of practice clearly articulated. Moreover, support provided by nurse educators was not restricted to skills but extended to organisational and professional issues. A clinical nurse noted that:

> We need to work on developing a nurturing environment, a learning culture because a lot of our staff just don't want to be involved in participating in their own learning … The nurse educators help staff appreciate that they need to demonstrate minimum standards and they try to encourage them. IDI CN 1 (7). L 370.

There was acknowledgement from all groups that nurse educators were constrained by the demands of the organisation to respond to constantly changing legislative and professional standards which absorbed considerable human and fiscal resources. Thus nurse educators may have become compliant and focused on regulatory imperatives in an effort to be judged favourably in the organisation. Some nurses wondered if the effort might be channeled more effectively into other activities.

> We see them with mandatory training, making sure we've got our mandatory training up to date but nursing is more than mandatory skills. IDI CN 1 (1). L 24.

The pressure to meet externally determined requirements is supported by Garcarz and Wilcock (2005) who assert that organisations are compelled to identify training priorities related to statutory requirements and key skill sets (mandatory training); and to consider national targets which may see a reallocation of resources (such as nurse educator time) and financial control.

The requirement to focus on other short-term organisational issues such as the introduction of new equipment or policy changes tended to cause tension, foster learner disengagement and at times, divert nursing education services. Such situations required the nurse educator to reflect on the emergent circumstance and to reconstruct actions. Short term issues assumed priority and the nurse educator had to respond to these and to the interests of nurse unit managers and other service users. A line manager explained:

> Education and research are core components of our organisation and should be. I don't find it is necessarily supported because we don't have the funds … like it's not in words but more in action. We focus on mandatory training without ever talking about what should necessarily be happening, what these people should really be doing, what we want to develop. … Other people could do mandatory training. IDI LM 1 (13). L 383 / 387 / 399.

These observations are consistent with those of Munro (2008) who argued that satisfying both organisational and individual learning needs creates tension and a disjuncture between individual, professional and organisational development.

There was also a sense that nurses were too busy, or time poor, to participate in continuing professional development activities. Nurse educators provided services that, due to competing work and personal issues, were not always valued. A clinical nurse explained:

> Well because the staff are too busy they come to work to do a task, they are not motivated to do anything else besides come to work and do a task and that's their lot in life. Inservice they don't think about, professional development. … When you do have an inservice you have to literally drag them out to get them to go. So lack of motivation and a task orientated workforce…They want to be spoon fed for any ideas coming

> through and are also sort of are unwilling to see any different approaches to nursing practice. They just want to continue on as a task, because they haven't got time to change because the wards too busy and they've got 8 hours to do a shift. IDI CN 1 (9). L 140.

A number of authors have identified barriers to the participation of nurses in continuing professional development that include personal or organisational resistance, shortage of staff, work, work release difficulties and lack of advanced notice (Barriball & White, 1996; Gallaher, 2007; Gould et al., 2006; Skees, 2010). An additional claim, albeit in a non-nursing context, is made by Billett (2001, 2004) who observed that reluctance and/or disinterest is perhaps the most common factor undermining participation in education programs. In some cases this results in weak learning outcomes in important areas of workplace practice and capacity building.

The assumption from the above excerpt is that some nurses are less interested in professional development because they are more focused on self-preservation. Nonetheless, nurse educators were seen as pivotal in encouraging engagement, or finding creative ways to satisfy mandatory and requisite requirements. The educator role was thus critical in enhancing perceptions of professional interaction and individualising strategies to address self-preservation. A nurse manager stated:

> We need to encourage the staff to be much more proactive. I hope that we can use the educator again to guide practice and initiate reflection on how staff think about their practice so they know what is expected of them. IDI NUM 1 (6). L 220.

While participants agreed that nurse educators played an integral role in constructing workplace learning this was not considered the sole responsibility of nurse educators. In reality, however, the main impetus for this learning was relegated to the nurse educator 'to drive' as part of their role. A nurse explained her experience of the context of learning:

> The cultures of nursing and organisations have the responsibility for standards of practice and for that ongoing development of staff so they just don't come to work and stagnate. This responsibility sits with the profession and the organisation and all staff, not just the nurse educator. I've asked this question of the nurse unit manager. The educator alone is not able to generate and or maintain this culture. We haven't generated a culture of development and learning or that of the knowledge worker well in nursing. We let people come to work, take the money and go

> because we are often short staffed and we can't let nurses go. So we let them write their own tickets rather reinforcing standards. IDI CN 1 (7). L 370.

Studies undertaken in the UK and Australia (McCormack & Slater, 2006; Shanley, 2004) have found that staff health education positions are crucial to the development of a learning culture through a work-based learning model. While similar perceptions were found, contradictions in expectations were also observed. Conway and Elwin (2007) argued that the success of a clinical educator rests on an ability to create and manage context appropriate learning and to influence and lead change. The perception of participants in the Conway and Elwin (2007) research was that nurse educators were a flexible resource who understand specific learning needs in the context of practice in a clinical environment with changing workplace demands. In this current research, the nurse educator was seen as an adaptable resource that assumed multiple functions such as a primary safety net in supporting staff, a work unit resource, an education expert, confidante, upholder of practice standards, and leader as determined by the expectations of others.

The view that responsibility for promoting learning should be shared has little effect if line managers do not support learning, or if work practices are inconsistent with learning opportunities. Nurse educators were seen as the major force in persuading others to critically appraise and consider the value of ongoing education. As explained by a nurse educator:

> In my opinion the majority of the nurse unit managers and other managers are overwhelmed by the operational part of their work. They never have a chance to stand back and appreciate what's happening with education and be proactive. Nurse educators, nurse unit managers and managers need to work together to look at these issues and have discussions with staff to look at reasons why things are happening. Let people evaluate their own practice and reflect on what they are doing and how they could do things better and provide better education supports. IDI NE 1 (15). L 56 / 238.

Nonetheless, a higher degree was not a pre-requisite for the educator role and this may have underpinned a tendency to focus on clinical support rather than educational principals and scholarly pursuits. To effectively promote critical analytical skills and engagement by others in workplace learning, nurse educators need to be highly skilled professionals (Guy et al., 2010; Jarvis, 2005). The view

expressed by the participants was that nurse educators should demonstrate effective clinical knowledge and skills underpinned by education. However, this was not necessarily the case in a system where qualifications for nurse educators were not clearly prescribed and where educators rose quickly through the ranks. A participant noted:

> People just sort of fall into these role sometimes and I don't know whether they ever really learn what it is to be an educator and they then just fall into the habit of watching some colleagues which may or may not be the right role model. They have to have some type of specific qualification related to what they are doing. IDI LM 1 (13). L 359.

There was, in fact, the potential for educators to never acquire the optimal skills, educational expertise, and awareness of the importance of their influence on the learning experience of others. It was acceptable for a nurse to rise within the education ranks without qualifications and particularly at times of national skill shortages (Queensland Health, 2006a) although it was agreed that once the nurse became a nurse educator further study would be valuable. A focus on the here and now and on clinical activities, rather than on problem solving, critical thinking and the application of the principles of adult learning, was not perceived as beneficial by line managers. Further education for educators was critical. The following line manager participants explained:

> They haven't got the educational knowledge that they need. I need nurse educators who have specialty knowledge and skills and higher levels of educational knowledge if they are going to take us where we need to be in the future. IDI LM 1 (2). L 113 / 226.

> Staff expect nurse educators to be knowledgeable and to have completed post graduate studies … Most would expect nurse educators to have completed some form of education research otherwise how could they reliably offer suggestions about education and foster a culture learning. They look at the educators to be their guides where education is concerned. IDI LM 1 (2). L 186 / 231.

These views are reflected in studies undertaken by Gaita (2000), Challis (2001), Neese (2003), Shanley (2004), Bellack (2005) and Gallagher (2007) who contend that nurse educators need to be lifelong learners, that there is little truth in the notion any one can teach, and that, if nurse educators are unable to effectively translate principles of adult education, this will have a negative impact on clinician engagement in continuing development.

While there was an expectation that nurse educators would make the role their own, how the role evolved depended largely on the competing interests of the work context. An assumption was that nurse educators would adapt to divergent expectations while seeking to adhere to the tenets of adult education in an environment where clinical care is core business. This situation created tension whereby the nurse educators had to reframe actions in order to sustain confidence in their knowledge and skills. Impression management is an important consideration if an educator is to achieve credibility in constructing workplace learning. Hence they generally engaged in reflection on their actions and educational initiatives, and attempted to increase their visibility in work units to increase acceptance and support for the role and services provided.

It was agreed that the immediate availability of the nurse educators (to support staff in the workplace) facilitated their ability to capitalise on learning opportunities and to address gaps in knowledge that may impact on patient outcomes. The key to acceptance and viability of the role was that the nurse educator was clinically credible and readily available to support work unit learning as the need arose. It was noted that nurse educators who were not seen as credible were often marginalised.

The nurse educators in this research made valiant efforts to retain ownership of the role and their job descriptions defined the purpose and parameters of the role. But in reality and given the context of a clinical environment with a focus on clinical care, others including nurse unit managers defined the breadth of day to day role application and achievement of outcomes.

Studies undertaken by McCormack and Slater (2006) and Conway and Elwin (2007) also concluded that nurses in workplace education positions contribute to the development of an organisational learning culture, promote consistency of education within facilities and maintain support processes all of which decrease the burden of work for others. Additionally, as part of their workplace learning support function, nurse educators are often required to support the nurse unit manager and other staff and to assist in addressing performance issues within work units. For the participants, this function involved organising support and assessment processes,

developing learning support contracts in consultation with the staff and nurse unit managers, and assessing professional standards. As the nurse unit manager group noted, nurse educators had specialty knowledge/skills and additional support systems (other nurse educators or nursing director education) to assist them to fulfill this responsibility. Furthermore this was perceived as being accountable in supporting learning and moreover educators had more time than others to address performance issues. As such the educators were required to reinforce staff expectations and standards of performance as defined by others. Line and nurse unit managers also relied on the nurse educator to determine strategies to address clinical incidents and episodes of unsatisfactory performance. The following nurses explained that:

> Nurse educators are involved in supporting nurse unit managers in performance management. If a nurse has performance issues, the educator would be involved with the nurse unit manager in putting an education plan around that person's practice. IDI LM 1 (4). L 9.

> The ongoing battle of performance appraisal and development is another way the nurse educator contributes well. Because she will flag anybody she thinks needs support it's identified and addressed so they can be helped not to struggle. IDI LM 1 (9). L 394.

For Billett (2001), the effectiveness of workplaces as learning environments should be judged on the basis of the conceptual, procedural routine and non-routine activities developed to permit workplace performance. Participants similarly noted that while learning and working were interdependent educators were relied upon to champion activities that encouraged learning in work units. Furthermore, the educators could not function effectively or positively influence learning if unable to establish and maintain supportive relationships. While, predictably, the nurse educator group concluded that their contribution to clinical practice and safe patient outcomes was more expansive than considered by other participant groups, there was no dispute that nurse educators acted as a valuable workplace resource.

Shared meanings and consideration of differences within symbolic boundaries reinforced perceptions of the nurse educator as a safety net resource, gate keeper, trouble shooter and facilitator of a learning culture in workplace units and/or across facilities. However, interactions between individuals and groups impacted on the ability of the nurse educator to fulfill these roles.

5.2.1 Engendering a Learning Culture

The sub-category, *engendering a learning culture,* refers to those factors that shaped the capacity of nurse educators to construct a culture of workplace learning. Such factors include visibility and engagement in the workplace, systemic tension and disparity in expectations. An inability of the nurse educator to meet service consumer expectations reduces the capacity to construct effective workplace learning. As such, this can lead to a lack of effective employee workplace learning and negatively impact on nurse educator outcomes and on organisational performance (Billett, 2001, 2004; Mathews, 1999; Murphy & Calway, 2008; O'Connor, 2004; Schoonbeck & Henderson, 2011; Scribner, 1999). Mead (1936) argued that learning, as the basis for action, should be regarded as a social process of interaction. Thus the premise of engendering a culture of learning in an organisation such as a hospital is that learning should be located in a context that promotes the appropriate values, status, and expectations to facilitate learner engagement and application to practice.

Professional interests are requisite components of the development of nursing and according to Schutzenhofer (1991), the success of these efforts calls for collaboration and shared meanings between nurse educators and nurses. Schutzenhofer (1991) affirmed that fostering scholarly pursuit in the clinical setting is an essential feature for the development of nursing as a profession. There is no doubt that even today, as Schutzenhofer (1991) established, nursing has difficulty translating scholarly pursuits into the practice setting. These difficulties may arise where the provision of support in health care organisations is perceived as inadequate and inconsistent and where there are no shared objectives. Any disjuncture may relate to perceptions of self-identity, or what participants understand about nursing from their education and experience and encounters in the "real world" (Blumer, 1969). In this research, the success and satisfaction in learning varied depending on participant perceptions of nurse educator engagement and collaboration.

5.2.1.1 Visibility and Engagement

I want them on the floor

The concept of visibility is considered to be the extent to which performance in a role can be readily observed by others (Merton, 1968). According to Roberts, Roberts, O'Neil and Blake-Beard (2008), those who have high visibility are exposed to more public attention, whereas those with less visibility receive less focus on their attributes, actions and behaviours. Additionally, social identity is considered to contribute in determining the degree of visibility people and groups gain within organisations (Roberts et al., 2008).

According to Brighenti (2007), visibility is a metaphor for knowledge and a social process in itself consisting of key features of relationship, strategy, field and process. Relational visibility is linked to watching that occurs among people and the intimate connection of seeing and being seen (Brighenti, 2007). By its very nature the relational aspect of visibility implies that asymmetries and distortions of visibility are the norm given its relationship to subjectifcation and objectification (Brighenti, 2007).

Taylor (1992) similarly argues that recognition is a form of social visibility that has consequences for relationships between minority and mainstream groups. However, the positioning of one's visibility raises the issue of management of social image and the terms of visibility threshold (Brighenti, 2007). Brighenti (2007, p.330) contends that "distortions in visibility lead to distortions on social representations, distortions through visibility". As such, visibility generates individual and social category identification (Brighenti, 2007).

While the flexibility of the nurse educator was perceived as a positive attribute it also provided space for criticism. In order to meet the expectations of adaptability, flexibility and leadership and to sustain availability (primarily at the discretion of the nurse unit manager) nurse educators had to continuously prove themselves. There was an overall sense that unless the nurse educators were visible in a clinical work unit they were not working. The concept of visibility was explained as follows:

> I expect the nurse to be visible and in the ward. I know that she has four areas so one would assume that she is in other areas if she is not in my ward. However, I don't know. I expect her to know which staff need support and then be available to provide the support they need. I have

> no idea about the hidden work of an educator. I just want her on the floor assisting the staff. IDI NUM 2 (10). L 84 / 86.

> They expect us to be in each ward all the time. But with three wards that is impossible. They seem to think that if I am not in the ward I am not doing anything even though I am in one of my other wards. IDI NE 1 (12). L 247.

Perceptions of visibility underpinned appreciation of the role since the nurse educators were not based in the clinical area and apparently coming and going as they pleased, irrespective of the work unit workload. It was proposed that where the nurse educator was not consistently visible in the work unit, it was difficult to ascertain if appropriate practice standards were being demonstrated. The assumption was that if an educator made a concerted effort to be visible more effective relationships would be generated and learning activities more likely to be supported. Line managers also considered that the extent of support provided for staff by the nurse educator would be easier to monitor if visibility and engagement improved. One nurse unit manager noted:

> I rarely see the educator and then you know for only brief periods of time so there is little interaction and visual support for patient standards at this point. However I would like to see that happen more. IDI NUM 1 (2). L 155.

The nurse educator group, while recognising visibility as an issue, attributed such concerns to a lack of understanding of their work. Historically, nurse educators have been allocated numerous clinical work units (on average, three or four) or, in some instances, geographically dispersed hospitals (such as rural facilities). It was physically impossible for a nurse educator to simultaneously appear in multiple work units. Nonetheless, visibility in a physical setting was a measure of contribution. This was referred to by participants as 'being on the floor', 'on tap', or doing 'the bidding' of staff and the nurse unit manager and being available 'in case they are needed to support a staff member as others are busy with clinical work'. As one explained:

> Because we're very visible on the floor, I think that has helped enormously in keeping ties, keeping away from the petty issues and keeping focused on actual education as opposed to some of those organisational niggles that come up from time to time. It also helps support learning in the unit. IDI NE 1 (18). L 355.

Gauging visibility is a process that is conceptualised as cyclical and embedded in the recognition vulnerability paradox, which occurs within the context of complex working conditions (Bonita, Hall, Bermbach, Jordan & Patterson, 2008). To gauge visibility workers monitor the work environment and interpret and evaluate the context of practice to determine the meaning of their visibility (Bonita et. al., 2008). Through gauging their visibility a worker can determine strategies to manage differences in understandings and either increase or decrease visibility and recognition.

Workers who feel valued are comfortable with their visibility because they are acknowledged through symbolic and material recognition such as being viewed as part of a team and having access to supportive relationships (Bonita et. al., 2008; Cohen, 2004). A positive social environment promotes a sense of self-worth, enhances positive emotions and fosters worker visibility (Cohen, 2004). In this research, demands for efficiency, visibility and engagement in some work units appeared to create a culture that required a high degree of nurse educator visibility and penalised absence whatever the reason. This saw nurse educators situated in a minority position in interpreting visibility. The problem for the educators was defining visibility particularly given the prevailing view of an educator as a safety net and readily available. As a consequence, they attempted to strategically manage their visibility by becoming more or less visible for the sake of projecting a favourable image (Roberts et al., 2009).

This management of visibility caused work unit tension and differences over nurse educator engagement and role attributes. In such circumstances, educators faced exclusion from work units where they did not meet nurse unit manager expectations of visibility. Alternatively they were subjected to increased scrutiny and surveillance from the dominant group which made their actions and behaviours more noticeable. Managing scrutiny involves a delicate balance between accommodating the understandings of the majority group and conforming as a team player to reasonable expectations so that contributions are not threatened (Roberts et al., 2008). Nurse educators in this research generally juggled their actions and interactions so perceived shortcomings were not used as a rationale to replace them

in work units. However, attempts to temper understanding about the role and clarify identity were not always successful.

From the above, it appears that irrespective of affirmations of role importance the nurse educators experienced marginalisation and excess scrutiny as their visibility and engagement was monitored by others. In response, there was a tendency for nurse educators to assume identities that were aligned to the role expectations of others. This resonates with Goffman's (1959) argument that individuals will modify behaviour and actions according to the acts of others. Actions and interactions have implications for how others view, evaluate and treat educators and for self-identity. If a nurse educator, for example, is not seen to be conforming to nurse unit manager expectations information relevant to the educator role may be withheld (e.g. on staff performance issues). A lack of inclusion thus impacts on nurse educator visibility, engagement and effectiveness. A participant noted:

> They do contribute, or at least have the potential to contribute, to clinical practice and continuing professional development but some of it is variable. It is people dependent rather than role dependent … Nurse educator visibility, engagement, interest and support varies again based on the person. IDI NUM 1 (2). L 357 / 455.

The context of nurse educator interaction also shaped workplace impressions. Even though diversity within the educator role was recognised this was also posed as one reason why expectations were not met. Moreover, the absence of clear measures of nurse educator contribution shaped beliefs about their ability to construct effective workplace learning. Hence, the majority of nurse educators worked hard to influence users of their services, particularly nurse unit managers, so that they might be judged favourably. As such, in an attempt to align actions with expectations, nurse educators needed to be highly visible and actively engaged at every opportunity, even though these actions may not be fully supported in the workplace. Two nurses noted that:

> They should be visible and present and available to help staff when it is needed. IDI CN 1 (3). L 64.

> I think they need to be visible for our staff to know that they are around and that they are actually working for them and we've got, we very rarely see our nurse educator, except when she wants to do something or she'll send down an instruction saying 'I'm having an inservice on this

> particular date in your unit'. Now there's no real communication with us as to whether that time is available or whether there are sufficient or appropriate staff on duty at that time and that becomes quite troublesome actually. IDI NUM 2 (8). L 19.

But there was no consistent view on what constituted an appropriate level of visibility and engagement. For example, many staff members worked shifts out of normal working hours and had no direct access to a nurse educator and felt unsupported. Indeed, the line manager, nurse unit manager and clinical nurse participants identified lack of obvious engagement as a central criticism of the nurse educator role. Yet, and as argued by O'Shea (2003), for some staff members the nurse educator will never be sufficiently visible.

Further to the above was the view that these expectations were contingent upon nurse educator personality, relationships between the nurse educators and nurse unit managers, available infrastructure and a culture of supporting education initiatives within work units and facilities. Nurse educators responded by increasing visibility to generate a positive impression often to the detriment of other aspects of their role. A nurse educator explains:

> I guess the role has evolved and changed.… We're probably not selling ourselves as much as we should and we're not as visible as the clinical facilitator even though you try to be visible. I think nurses like you to be visible all the time or they don't think that you do actually anything. IDI NE 1 (8). L 76 / 84.

The only participants to appreciate fully the impossibility of nurse educators being simultaneously physically present across work units were the nurse educators themselves. As one noted:

> Because of the visibility of the educator, the input of the educator and personality between the nurse educator and the nurse unit manager and lots of other issues at the moment I don't think there is a terribly positive outlook. IDI NE 1 (11). L 48.

Value judged by visibility, while being perceived as the other, manifested as a constant struggle. Lack of visibility meant that some nurse educators were labeled as superfluous and this diminished nurse educators and nursing education in terms of professional identity. It was asserted that some 'sit back' and do not apply themselves fully to the role. As two nurses explained:

> Some nurse educators have been in the role for a long time and haven't necessarily changed their methodology across the years … There is some degree of a learned culture that is not necessarily to our advantage … I mean it comes back to the learning process rather than the teaching practice so they should be doing that. Some are at the end of their career and how realistic is it to expect them to change their work practices after they have been doing the same thing for about 20 years … Some are not clinically competent anymore. I think that is a risk. IDI LM 1 (13). L 120 / 128 / 220.

> I hate to admit this but there is some dead wood out there, who haven't kept up to date and who can't provide the support that they should to clinical units. This causes a problem in delivering education services. IDI LM 1 (2). L 50.

Judging nurse educator value based on visibility creates a distorted perspective of the complexity of the role and the full extent and nature of skills and knowledge nurse educators contribute to the workplace and profession. Nonetheless, in this research, visibility was the concept most associated with nurse educator worth and the extent to which they engendered a positive perception of workplace learning. As a nurse unit manager stated:

> Because educators do not market themselves they don't talk to people and are not visible. … It is person specific. All educators should be proactive and visible. IDI NUM 1 (8). L 69 / 79 / 89.

Nurse educators are expected to be proactive, visible and engaged with colleagues, and to initiate strategies for engendering workplace learning. Others wanted the nurse educators to lift their profile so that staff members were clear about expectations. A consistent premise was that while perceptions of nurse educator visibility varied across groups, visibility in the work unit became the dominant, if arbitrary, measure in determining the value of the educator role. It was not individual nurse educators, stakeholders and outcomes that shaped the ways in which the effectiveness of nurse educators was conceived. Hence, expectations of nurse educator visibility and engagement were inadequate as a definitive measure of nurse educator role value and contribution.

In the contemporary work environment organisations expect employees to be proactive, to show initiative while demonstrating engagement, and to be committed to high performance standards (Bakker Albrech & Leiter, 2010). But although there is widespread interest over what comprises workplace engagement

there is little consensus on definition (Schaufeli & Baker, 2010; Soldati, 2007). Kahn (1990, p. 694) defines workplace engagement as "the harnessing of organisation members' selves to their work roles by which they employ and express themselves physically, cognitively during role performance". There are varied dimensions to the psychological conditions in the workplace that lead to engagement (Bakker, Schaufeli, Leiter & Travis, 2008; Maslach, Schaufeli & Leiter, 2001; Schaufeli & Bakker, 2010). The general understanding is that engaged employees work hard and are fully immersed in their work activities while demonstrating enthusiasm about their work (Bakker & Demerouti 2008). Thus engagement is considered a broad construct consisting of a state, trait and behaviours that bring a blend of emotional energy and discretionary effort to one's work and organisation (Macey & Schneider, 2008).

In considering these definitions and views it seems that work attributes and demands and personal characteristics influence employee engagement (Crawford, LePine & Rich, 2010). Furthermore, Macey and Schneider (2008) argue that challenging situations promote engagement when employees trust that investment of time and energy will be rewarded in a meaningful way. If workers consider that coping efforts will be effective and meaning is experienced in meeting challenges they become more willing to invest energy to adopt more active problem-focused styles of coping and consequently enhanced engagement (Crawford, Le Pine & Rich, 2010). However, excessive work demands and lack of resources undermine engagement, standards and productivity and may potentiate burnout (Bakker, & Demerouti, 2008; Bakker &Schaufeli 2008).

In the current research role ambiguity, conflict, de-valuing and bullying were experienced by educators. Thus the nurse educator may have come to believe that irrespective of effort this was insufficient to satisfy each expectation and/or demand. Hence energy dedicated to meeting expectations may be re-directed to coping with the anxiety and frustration associated with conflicting roles and expectations being unfulfilled. Research has shown that resources invested in addressing negative emotions and psychological threat are associated with decreased levels of motivation and engagement (May, Gilson & Harter, 2004; Porath & Erez, 2009). Thus people become less willing to invest energy to deal with obstacles directly and tend to resort

to passive and emotion focused styles of coping. This is consistent with findings from the application of self-determination theory where threats to satisfaction from diminished competence, relatedness and autonomy weaken motivation (Meyer & Gagné, 2008).

Constraints such as those experienced by the educators in this research underpinned negative relationships, reduced engagement and increased the potential for criticism. Ambiguities and apparent unresolved tensions about the nurse educator role between study participant groups meant that the degree of collaboration in nurse educator daily practice varied. The nurse educators regularly put aside their priorities (e.g. developing learning resources) to respond to the demand of others (to be 'on the floor' and visible). This differentiated the nurse educator role from the roles of others (such as line managers) who were able to focus on work unit clinical care. This positioned the nurse educator between clinical and education activities and increased tension from both inside and outside the role.

5.2.1.2 Tension in the System

Some managers don't view it like that

From the above, it appears that nurse educators generated a certain degree of tension in the system and were aware of the politics surrounding their role. Tensions manifested between clinical and education priorities with primacy invariably given to clinical needs. Clinical work was considered core business and as such more important than education. Educational initiatives, other than those related to minimum mandatory and requisite skills were often posed as optional extras. Hence views diverged on what should constitute education within the clinical setting. This tension manifested most obviously within the relationship between nurse educators and the nurse unit managers. One nurse educator noted that:

> I believe that the majority, or all of the nurse educator role, contributes to clinical practice and I think that is really important. Some managers don't view it like that and this causes tension and difficulties in achieving outcomes. But with change in leadership they see the soft subjects as very important to the clinical environment and you can't separate things out. It is very difficult to gain support if the leader doesn't value learning and provide time. IDI NE 1 (11). L 709.

Nurse unit managers noted that relationships should be collaborative but that this was not always the case and the result was awkward interrelationships and a reduction in nurse educator contribution and ability to construct work place learning. Communication and collaboration were found to be less than optimal as nurse educators struggled to know what was expected of them. While the concept of collaboration was evoked this was variable and the nurse educator generally coordinated education activities and adapted to expectations and monitoring of others. Two nurse unit managers explained that:

> The relationship between the nurse unit manager and nurse educator should be collaborative. You would get more out of them working together than disparately. I would be lost without the nurse educator (because) it would greatly increase my workload. I definitely need her to be there when education is required. IDI NUM 1 (8). L 153 / 157 / 169 / 175.

> There is a bit of collaboration, when we can track her down and keep up with what is going on. The nurse educator doesn't meet regularly with the nurse unit manager. There should be some change to increase interaction between the nurse unit manager and the nurse educator that way I would be know what she is doing. IDI NUM 2 (10). L 91 / 97.

While they occupied a subsidiary role nurse educators were perceived responsible for the status of relationships with nurse unit managers. The onus was on the nurse educator to make it work and reduce the potential for conflict. Thus conforming to the values of nurse unit managers was crucial even though it meant that the nurse educators relinquished other important values. Of importance here is that the efforts to define and develop the role of the nurse educator rested on individual negotiations over work rather than formal role criteria and regulation as was the case with nurse unit managers. This is evident in the following statements from two nurse unit managers:

> It's absolutely vital that the nurse unit manager and nurse educator interface. I'd be lost without the nurse educator. IDI NUM 1 (8). L 423.

> They're kind of a 'safety net'. But they're only utilised when there's a need…Like something has happened. There's no full engagement. I know there are steps in place if needed…Somebody to call but there is no interactive basis. The educator should be looking at the strategic 'big picture' and liaising with the nurse unit manager a lot more. Their personality has an impact on that. The support for the nurse unit manager by the nurse educator is extremely important. There is a barrier to some extent. IDI NUM 2 (3). L 157 /169 / 173 / 195 / 410.

Collaborative relationships did not always exist and nurse educators were not generally considered as having equal status to nurse unit managers. The line managers often judged relationships or interactions between nurse educators and nurse unit managers as ineffective. This may be because on the one hand, nurse unit managers enjoyed high prestige associated with responsibility for resources (human, fiscal environmental) and on the other hand, nurse educator status was nurtured through personal relationships given their positioning as the other. The nurse educators actively sought to make sense of uncertain contexts in pursuing education activities. Unlike the nurse unit manager the nurse educator needed to constantly reframe and adjust behaviours and actions to accommodate the interests of others across multiple work units. A line manager explained the relationship in the following terms:

> There are definitely territorial issues about "this is my role and this is your role" and they don't meet. We have had to work really hard at saying you know the educator's role is to support what models you operate and the clinical knowledge, abilities and competency the staff require … The personality and turf issues impact on their ability to effectively do their role because there are constant barriers being to be put up. IDI LM 1 (12). L 132.

As such, tensions in interactions were widespread and generally based on territory and power imbalances. For example, clinical nurses often considered their relationships with nurse unit managers more important than those with nurse educators. The nurse unit manager was the position they answered to and hence the preference was to support line manager decisions. Group perceptions are shaped by a shared cultural identity and the nurse unit manager role more so than that of the nurse educator, was symbolic of a salient identity. As explained by a clinical nurse:

> I don't think that there is a good relationship or collaboration in terms of workforce planning or planning on a ward basis. I don't think the nurse educators are involved in that at all. I think that they are definitely seen to the side and they are not called unless it's an absolute emergency. IDI CN 1 (5). L 36.

The difficulty in balancing clinical with educational needs was recognised by Underwood et al., (2004) who argued that professional practice and ongoing professional development may be at risk in an environment driven by clinical imperatives. Competing demands, as Munro (2008) argued, give rise to disparities between individual, professional and organisational learning.

For the participants, operational tension had the potential to undermine educational initiatives by circumventing nurse educators and services and resulting in disrupted interaction. As noted earlier and to counter this tension nurse unit managers, at times, replaced the nurse educator with a clinical nurse/clinical facilitator (RN/EN Support), or other resources, to undertake education activities. Because clinical nurse/clinical facilitators (RN/EN Support) and resource staff report to the nurse unit manager, they were more inclined to be compliant to maintain relationships with line managers. This strategy may have reduced tension between clinical and educational imperatives, but did little to foster nurse educator acceptance in the workplace or nurse education job satisfaction. Furthermore, the education undertaken by clinical nurse/clinical facilitators (RN/EN Support) was perceived as operational and focused on mandatory and requisite skills and capacity building. One nurse educator explained that:

> The clinical nurse facilitator role has become confused. They are supported and managed by the nurse unit manager who often uses them instead of the nurse educators. I have a good relationship with the clinical facilitator but she is often caught between doing what the nurse unit manager wants. Often they are requested to provide education when it is not required. IDI NE 1 (8). L 283.

There was also evidence of tension between clinical nurse/clinical facilitators (RN/EN Support) and some nurse educators. The focus of nurse educators, for example, was often on questioning practices which was frustrating for others when the work unit focus was on the here and now. It appeared that clinical nurse/clinical facilitators (RN/EN Support) assumed a functional role in contrast to that of the nurse educator. The former resented having (what they perceived was) their integrity questioned and particularly as the nurse educator was not their line manager. The latter, because of partial exclusion and positioning as the other, lacked work unit authority. Decisions and advice were, therefore, ignored when not aligned with prevailing work relationships and work unit priorities, irrespective of educational needs. These situations contributed to the marginalisation of the nurse educator and the difficulties in establishing effective professional relationships and thus negatively impacted of the nurse educator's ability to foster learning and a learning culture.

The broader twofold responsibilities of clinical practice and education caused further separation between groups especially when the nature and complexity of the education role were not fully appreciated. In general, nurse educators and line managers both perceived the nurse educator role as specialty practice largely similar to that of other nursing classifications. A critical difference was the construction of the educator position as a specialty position external to the central workings of the clinical unit. Construction as the other positioned nurse educators as subservient where nurse unit manager views differed on the worth of education support. What also propagated the view of otherness and thus tension was that the nurse educator position was classified at the same pay award level as that of the nurse unit manager and as such, the educator was not required to report to the manager. Nonetheless, informal processes reflected the disparate positions of power. Tension arose particularly where the nurse educator was considered a 'gap filler' or someone to be available at all times and their education expertise trivialised. When the degree of tension was too pronounced education services were not supported and workplace learning became fragmented. Line managers described the tension as follows:

> There is tension in some ways related to the degree of separation. The nurse educator needs to be able to support the work environment to change practice and support standards without undermining the leadership of the nurse unit manager. It needs to be collaborative and mindful of constraints. IDI LM 1 (1). L 71.

> The nurse educator does a mixture of planned and predictable work combined with emergent … There is constant tension between those things and there is also an element of unpredictability (and) the nurse educator needs to be flexible enough to jump in and fill a gap if it occurs. IDI LM 1 (12). L 26 / 30.

Yet the function of the nurse educator was also to challenge the status quo. If this function was absent then parochial clinical environments with a focus only on what happens in the work unit would prevail.

> Nurse educators encourage problem solving and question practice. They make us look at what and why we undertake activities. This helps us consider options and providing better care based on evidence. IDI CN 1 (6). L 148.

This view is consistent with that of McCormack and Slater (2006) who purported that clinical educators contributed to organisational cultural change and assumed a key role in the education-practice chain. These authors also assert that an

underlying tension was required if one in a clinical education role was to encourage inquiry, reflection and practice change.

This tension may also act as a constraint on the performance of the nurse educator and negatively impact on support for education services or lead to the perception that the nurse educator was not performing to key stakeholder expectations. A nurse educator may have adhered to role requirements but priorities and expected outcomes varied. Irrespective of cause, the contexts required the nurse educator to adapt in an effort to reduce tension. The demands, culture and immediacy of the workplace were paramount and the nurse educator's role was to first respond to these and second to stimulate a commitment to workplace and professional education. One line manager explained her experience noting that:

> There is constant tension…(and)…systems being what they are sometimes it is unpredictable as to whether people will be released to participate in planned events. So the educator has to be flexible enough to jump in and fill a gap if it occurs. The educator needs really good skills to support a work environment to change practice without undermining the nurse unit manager. So there needs to be collaboration and it needs to be mindful of the constraints, skills and needs of the work unit. These are important skills the nurse educator needs to influence practice. IDI LM 1 (13). L 30 / 173.

A study by Squires (1999) found that if nurse educators and nurse unit managers are unsure of their respective roles competition occurred and the nurse educator would constantly seek to blend in without belonging. The language and meaning expressed in the current research supports Squire's (1999) findings. The status of nurse educators as the other was incongruent with equal position and power to the nurse unit manager who held the balance of power over resources.

From the above we see that nurse educators were often conceived as subsidiary support, rather than integral to the work unit team. Nurse unit managers held the balance of power and ultimately determined the extent to which nurse educators were assimilated into the team. While location as the other reflected a power imbalance between the nurse educator and nurse unit manager it, in turn, fostered cohesion among nurse educators. Two nurses explained how they perceived the context:

> … some of the areas that tend to have the more junior work force and the more vulnerable work groups tend to depend more on their educator to be part of their team because there are more issues that tend to arise… The areas that are highly specialised and highly skilled, for example coronary care, the cath... lab, gastroenterology, those type of areas, they tend to very much run autonomously … and almost to a large degree there are barriers put up for the outsiders to come in. They are not necessarily seen as part of the team. IDI LM 1 (13). L 68).

> Even the senior staff members are really feeling the pressure of high throughput and education is what falls behind. The demands on nurse educators are always increasing and they are expected to continue to do more without any increase in resources. If the nurse unit manager chooses they are excluded. IDI CN 1 (4). L 387.

Such experiences shaped the nurse educator professional identity and created an in and out group culture with associated feelings of inferiority for the educator. Conversely, the experiences situated many nurse educators as the trusted others who were consulted where it was deemed inappropriate to talk to work unit staff or where there was a need for change.

At times, being the trusted other meant nurse educators were privy to sensitive information and involved in the politics of work units and the organisation. These situations altered perceptions of control and power between nurse educators and nurse unit managers. The following two nurses noted that:

> I feel comfortable going to them which is good but then I think they too need to learn what to do with the information that they are given and not try to solve all the problems of the world. They have knowledge of very sensitive information which sometimes causes conflicting feelings, particularly if it impacts on someone's career. IDI NUM 1 (6). L 192 / 194.

> I think the hospital employed nurse educator is very much tied up in politics, tied up in things that aren't probably necessary. Some of the things we are involved in are pretty stressful and have implications for people's careers. IDI NE 1 (1). L 75.

It has long been argued that a characteristic of nursing has been horizontal violence where nurses are inappropriately critical of other nurses in less powerful positions (Ashley, 1980; Duffy, 1995; Griffin, 2004; Roberts, 1983). Involvement in sensitive work (e.g. remedial support, final assessments linked to staff stand-downs) places additional pressure on educators. Increasing workplace demands and variable expectations place pressure on education services and individual nurse

educators. For the nurse educators, role dilution and negativity in relation to educator services lead to feelings of inadequacy and vulnerability. However, fear of failure or devaluing of services meant such feelings were often concealed. A nurse educator noted:

> People often ring up because they expect you to know or know someone or if you don't. Reliability is very important they expect feedback. Managing our workload is stressful. It's an issue because our workloads tend to get out of hand. You are expected to give a percentage of time to so many different activities. IDI NE 1 (12). L 673.

The experience is consistent with the Davis et al. (2005) argument that clinical nurse educators need to keep pace with the ever-changing nature and context of health care. Studies by Forster (2005) and Gould et al. (2006) also found that the capacity of nurse educators to adjust to changing workplace environments and to meet expectations is important for credibility. However, the view that a nurse educator can meet all expectations through a process of individual adaptation does not capture the complexities of the context of the nurse educator role.

In summary, tension in the workplace has a potential negative impact on relationships, particularly between nurse educators and nurse unit managers. If too pronounced, this manifested in a lack of support for education initiatives, a lack of engagement, and a bypassing of nurse educators and education services. Tension occurred in situations where the nurse educator did not fulfill the immediate needs of nurse unit managers and work contexts. Yet if nurse educators were to be effective some degree of tension was necessary in order to stimulate critical reflection and to bring about change. This meant that nurse educators questioned their identity and attempted to manage role impression as they struggled to be accepted. The result was that nurse educators often questioned their very identity and felt compelled to conform to the expectations of others and to accommodate strategies in an attempt to reduce tension over, and gain support for, the role and workplace learning activities.

5.2.2 Struggling for Identity

The sub-category, *struggling for identity*, refers to those processes that shaped the formation of the professional identity of the nurse educator within the context of practice. Significant influences included value attributed to the role and

the nature and extent of workplace difficulties encountered in enacting the role. Identities in this research are viewed as strategic social constructions created through interaction and negotiations that entail self-preservation or impression management and that have social and material costs (Goffman, 1959). Goffman (1959) argued that in organisations identities are shaped by social hierarchies and that there are varying degrees to which people control information others have about them. Goffman (1959) also asserted that agreement regarding roles will facilitate effective social interaction. In reality professional identity is multifaceted and consists of many sub-identities which may be in conflict as they involve contextual, cultural and historical factors (Coldron & Smith, 1999). Thus professional identity is what is used to make sense of oneself in a profession.

The nurse educator professional identity is hence understood to be influenced by context, formed in relationships, changing and involving meaning making (Ruhohotie-Lyhty, 2013). Therefore professional identity can be viewed as the lens through which individuals make sense of themselves in relation to contexts and the views and actions of others (Coldron & Smith, 1999). In this research, the nurse educator contexts of practice differed and varied views regarding the educator role were expressed by others to influence and guide nurse educator behaviour and to encourage conformity. As such, the construction of a nurse educator's professional identity occurred through interpretation and reinterpretations of their experiences. The ambiguities in expectations of others then lead to persistent uncertainty in the everyday work life of the educator and thus undermined the stability of their professional identity. According to Swann, Johnson and Bosson (2009), stable identities afford people a sense of order in their interpersonal relationships by encouraging a display of continuity in behaviour. Conversely, inconsistencies in actions such as a de-valuing of nurse educators and difficulties experienced in the workplace influenced how the educators self-identified as professionals.

5.2.2.1 Valuing

There is a bit of turf war

It is reiterated here that, despite tension, the role of nurse educator itself was perceived as worthy. Nonetheless the educator role was constructed as inferior to that of the nurse unit manager by participant groups apart from the nurse educators. One clinical nurse noted that:

> The nurse unit manager is the ultimate boss …because it's her ward. The nurse unit manager is responsible …. So basically we should be reporting to her. IDI CN 1(9). L 344.

Thus, although nurse educators were valued and seen as legitimate participants in decision making there were contradictory interests. The professional identity of nurse educators was the product of interaction between personal philosophies and professional practice and was a constant evolving process with identities developing and transforming and continuing throughout the nurse educator's career. In this research there were also disparate perceptions between rural and other participants. These differences possibly existed because, prior to 2007, changes to rural facility funding for nurse educator positions was not in place in each health service district. Rural nurses were grateful to have a support service similar to other facilities. The following participants described the value of rural nurse educator positions:

> The nurse educator provides facilitation and supports staff. She is like a conduit. They didn't have a nurse educator for rural facilities until recently … I don't know how anyone out here could have assured anyone was competent or had the core skills they needed. The 360 degree feedback about the educator is always positive. IDI LM 1 (6). L 317 / 325.

> In the rural district where I work the nurse educators are important as they assist and guide the staff. They're very appreciative, they never had an educator before and they realise how they value the educator and how much extra support they have. IDI NE 1 (13). L 540 / 548.

The rural participants aside, the nurse educators anticipated negative social acceptance and responded by adjusting actions and reframing meanings. The following nurses interpreted the differing perceptions of nurse educators as follows:

> There's a bit of a turf war with regard to the nurse unit managers (who) see the units as their area and they feel threatened … The problem is the nurse unit manager is just saying we don't need you, we'll call you when

> we do, so then it's very difficult to know where to start … Some nurse unit managers don't appear to accept the role. IDI CN 1 (5). L 102 / 120.

> The nurse unit manager is the person with the purse strings and the person who has to deal with the day to day problems…basically it's attached to the money, budget and staffing. Really this gives the nurse unit manager's job more clout. But I tell you they couldn't do without the nurse educators and the manager and they recognise that. However, the educators don't have the budget, they don't have the staff and they don't deal with the 30 patients a day. IDI CN (1). L 232.

As identified previously, value is not determined necessarily on the basis of knowledge and skills. Nurse educators seek to achieve a degree of connectedness (positive relations) (Swann et al., 2009) with those with whom they work. However, given variability in participant views of nurse educator value this did not always eventuate. This perspective is supported by the Queensland Health (2008b) findings that contested the view of nurse unit managers who perceived an inequity in work span, complexity, responsibilities and autonomy between their role and others of similar classification (e.g. nurse educators). The following quotes reflect ongoing power struggles:

> One of the areas that I think is a problem is the believed difference in workloads. Also whenever you've got two NO4s trying to work at the same point and achieve the same sort of outcome it always ends up in a power struggle. Inevitably, I find the nurse unit manager tends to win that power struggle and the nurse educator tends to be subservient. IDI LM 1 (13). L 168 / 172.

> I've seen situations where a nurse educator disagrees or does not support a direction to the satisfaction of the nurse unit manager and then the nurse educator may be moved to another set of work units and or the nurse educator may be bypassed and the clinical nurse facilitator used if the position exists. IDI CN 1 (1). L 228.

The nurse educator position as set down in the industrial award provisions was of equal value and skill to clinical positions of the same award classification/grade (e.g. nurse unit managers). Yet one line manager explained that:

> The nurse unit managers definitely believe that they are the boss. I know of a situation where the nurse educator knew her role and that what the nurse manager expected of her was not her role but because of a personality issue she delivered. The nurse unit manager said this is your role; this is what I want so it will happen. IDI LM 1 (12). L 237.

Conflict between professionals is considered unprofessional and breaches organisational codes of conduct. Nonetheless, in this research it appeared that the imposition of power in redefining the role boundaries of nurse educators was acceptable. In some work units, irrespective of the level of investment, nurse educators struggled for a voice and to have their work recognised as shaping practice. The nurse educators identified bullying as an issue, mainly in relation to nurse unit managers. Bullying is related to both individual and organisational factors, such as interpersonal conflict, power plays, and change (Salin, 2003; Zapf & Einarsen, 2003). The linguistic symbols colleagues used also connected people and created distance and separate groups. Uneasiness, withdrawal and reduced interaction were identified by participants and nurse educators were unsure of how best to respond. As a nurse educator noted:

> I've almost had a padlock on my tongue, that I'd like to know where that line is, and I know really it's not a line. I'd like to know where robust discussion starts and stops and so called aggressive behaviour takes over…. IDI NE 1(11). L 462 / 480 / 484.

It was difficult to question the nurse unit manager role because this role was essential to the effective functioning of clinical work units. This was not the case, however, for the nurse educator role as evidenced by regular reviews, cost cutting, service change and health care reform (Forster, 2005; Heath, 2002; Queensland Health, 2006a, 2008a, 2010a). Being the focus of ongoing review has reinforced the prevailing perception that the hospital employed nurse educator position is not core business in health care. Shanley (2004) notes that the continuing professional development activities of organisations that turn to cost cutting become diluted. The following expression from a line manager excerpt reflects this point:

> It is also interesting that nurse educator positions are often looked at in times of 'rational economic cut backs'. Probably because the majority has no idea what the full role of the nurse educator is and perhaps only sees the role through interaction they have with it on an individual basis. While they would see the nurse educator programs they don't comprehend the 'hidden' type of work that is integral to the role and how it supports nursing. IDI LM 1 (10). 26.

While the nurse educator position had value as a nursing classification the role in practice was considered de-valued through its marginalised position and lesser authority compared with nurses of similar classification. Nurse educators were constantly viewed in terms of what they were doing and how the role

responded to the expectations of other research participants. They resorted to compensatory behaviours to minimise tension between them and others. To achieve this, nurse educators also negotiated their own past histories in an attempt to deal with the social and organisational practices that form their professional contexts.

As indicated earlier, nurse educators were often experienced and accomplished clinicians but novice educators. This gave rise to a tendency for these educators to more strongly identify with their previous clinical roles than the educator position. This also eroded the professional identity of educators and undermined enactment of nursing education initiatives.

Thus, perceptions of the nurse educator professional identity shaped relationships between nurse educators and others. Not everyone agreed, however, on the significance or impact of those relationships. The relationship between nurse educators and nurse unit managers was significant and influenced perceptions of other staff of the nurse educator role. There were disparate views on collaboration, support, and value as perceived in relation to the nurse educator position. Moreover, nurse educators were viewed as primarily responsible for establishing and maintaining relationships, education initiatives and outcomes.

5.2.2.2 Work Difficulties

Expected to be everything to everybody

It is impossible to address the contribution of the nurse educator without considering contextual issues such as workloads, infrastructure support, interactions, access to staff, and support for education activities. Socially constructed role boundaries have implications for nurse educator role identity and ultimately their success and views of effectiveness. Additionally, the nurse educator's desire to collaborate with colleagues and to have the role and education services accepted could be viewed as a mechanism to obtain connectedness thereby aligning the professional identity of the role with organisational and work unit expectations.

The ability to achieve a learner-centred approach to learning was influenced by the work environment, the organisation, political imperatives such as funding and

the nurse educator's knowledge and skills and expectations of others. Engaging large numbers of staff while addressing organisational obligations in an environment that was not always conducive to learning was problematic for nurse educators. A line manager pointed out that:

> It is difficult for the nurse educators to have an individual approach to engaging the learner when they have to constantly respond to organisational training needs and have so many staff to support. Sometimes it has to be the same approach for all. IDI LM 1 (15). L 236.

These experiences are supported by other research undertaken in different contexts which refers to the nurse educator as a go between who attempts to fit learning and training around clinical schedules and imperatives (Bellack, 2005; Daly, Speedy & Jackson, 2000; Gibson, 1998; Goleman, 1998; Levitt-Jones, 2005; Robinson et al., 2006; Siler & Kleiner, 2001; Young & Patterson, 2007). They also point to the educator-manager relationship and the expectation that the former will adapt to the needs of the latter. As such and as these authors argue, it is often easier for the nurse educator to approach the learner as a passive consumer rather than facilitate learning.

The educator's use of passive strategies was at times the only alternative to convey knowledge of an important practice change given clinical priorities. As noted, nurse educator engagement in work units and access to staff to facilitate learning varied between work units and was dependent on the nurse educator negotiating workloads to accommodate the priorities and needs of others. However and as perceived, lack of engagement and visibility in work units was a central criticism of the nurse educator role and created difficulties for role identity and acceptance. Additionally, as the nurse educator was seen to set the direction for educator activities but full complexity of the role was not readily understood the nature and extent of their workload were not acknowledged. This further complicated the ability of the nurse educator to manage impressions of the role.

Judgments about workloads were contextual. For example, the impression was that while nurse educators were busy, the nurse unit manager role was busier. Nurse educators were not tied to work units in coordinating patient-focused activities and a plethora of staff. Nurse unit managers and clinical nurses thus saw

nurse educators as 'flitting' in and out of work units at 'whim'. Two nurses outlined their views:

> Part of the problem I see is, that both the nurse educator and nurse unit manager are both base NO4s. One of the areas I think is a problem is what is believed to be a difference of workloads. IDI LM 1 (13). L 168.

> We're spreading nurse educators too thin. We're asking one nurse educator, like everything in health care, to do a role for four or five wards. But nurse educators don't have a budget, or staff and don't have to manage 30 patients a day coming and going. IDI CN 1 (1). L 164/ 244.

Nonetheless, nurse educators, line managers and clinical nurses all agreed that nurse educator workloads were increasing and that the role was too diverse. At times this was attributed to the knowledge, skills and capacity of the individual. Yet there was acknowledgement of broader issues such as constant change, large numbers of inexperienced staff and advancing technology. Other studies have also identified similar factors impacting on the ability of clinical educators to achieve effective role outcomes (Davis et al., 2005; Hardy & Hardy, 1988; Ramage, 2004). Nurse educators were expected to juggle multiple realities to realise expectations and minimise potential work difficulties with little regard for the personal or professional impost. However, where responsibilities continued to expand, nurse educators were stretched and often only able to focus on basics such as mandatory and requisite skills. The following nurses explained that:

> In regional roles they are often expected to be everything to everyone and cover diverse area in which they may not have expertise. Sometimes I think there is too much diversity and they are asked to do too much. IDI LM 1 (10). L 39.

> I feel like our educator has enough work you know for two full time jobs. IDI CN 1 (10). L 108.

> I think the nurse educator role is just expanding and expanding as much as the poor person can do it you know. I think we need clinical facilitators. There is too much to do the role properly. You run all day and it is stressful. IDI NE 1 (10). L 392.

Line managers did acknowledge that increasing workloads and lack of professional growth and isolation impacted on the nurse educator's ability to develop in the role and meet expectations. These factors potentially limited the educator focus to operational activities of workplace learning. Two line managers noted their experiences:

> Educators do feel isolated. Some need a lot of direction and at the moment with restructure everybody's firing things at her. I think the role is too big for one person to do it is a huge job. IDI LM 1 (9). L 188 / 218.

> When their workload becomes too high they say, 'you know well my workload is too high' and they get absorbed in doing some of the operational things. I think a lot of the operational stuff is self-propelled sometimes. In some cases it may be because they don't have the knowledge and skills. I think there is a lot of threat perceived. IDI LM 1 (12). L 76 / 84 / 148.

The combination of diverse and expanding nurse educator work combined with the expectation of being a general resource diluted the responsibilities and attributes of the position. Indeed, nurse educator participants expressed frustration at being considered a 'jack of all trades', or a 'stop gap'. Two nurses put their views on nurse educators as a generic resource:

> They expect the nurse educator to know everything and to be there and to deliver whatever they want and need. Sometimes that mismatch between what people think what they want and what they actually need impacts on how staff view the nurse educator. IDI NE 1 (2). L 273 / 279.

> I would have to say that the nurse educator role is very broad and in some respects the nurse educator role is expected to be everything to everybody. IDI CN 1 (7). L 232.

Nurse educator interactions with others (and particularly nurse unit managers) were seen by participants as impacting on how they dealt with or responded to workplace difficulties. Nonetheless, often nurse educators were perceived as motivated, assertive and generally capable. The following nurse stated that:

> Unless nurse educators have a certain level of assertiveness and personal power it would be very easy to be pulled from pillar to post by different people. I think sometimes if in doubt give it to the nurse educator and sometimes that can make the role very broken. The nurse educator is not treated very well. IDI CN 1 (7). L 236.

The changing nature of work, workplace demands and work practices influenced workplace learning; however, determining the extent and impact of such work difficulties was challenging. DeMarco (2002) contends that nurses keep silent to avoid conflict and to maintain the status quo in the workplace. Yet this acquiescence reinforced the nurse educator as a 'safety net' rather than as a leader

who supports workplace practice and champions change and education activities. These conflicting views often located the nurse educator at odds with the nurse unit manager and others over work unit priorities and nurse educator value. The nurse educator was positioned as the other, who was a peripheral work unit resource, legitimately able to construct an identity (albeit continually varying) in the unit and guide learning and development, but without line responsibility for patient outcomes. Potentially this ambiguous identity in the workplace negatively influenced the nurse educator's ability to negotiate social relationships and perceptions of role value. Consequently it was the nurse educator who modified behaviour and actions in an attempt to meet expectations to engender effective workplace learning and acceptance in work units and the organisation.

5.3 Conclusion

Underpinning the category *constructing workplace learning* was a conceptualisation of the nurse educator as an essential feature of workplace learning. The function of the educator was to facilitate learning and construct a culture of learning in the workplace. Yet, in this research, while the nurse educator was perceived as the principal actor in nurturing learning, organisational legitimation of the role and associated support was subject to interpretation. As such, an educator's ability to construct workplace learning was shaped by work environments, the organisation and political imperatives. Thus, nurse educators experienced political and power tensions in the workplace where they were unable to establish and sustain supportive relationships, meet expectations, or develop and use systems and processes to advantage.

Where meanings were not shared role conflict was the result (McCall & Simmons, 1978; Stryker, 1991). Meanings constructed around the nurse educator role were often contested and this gave rise to difficulties for educators in making the role their own. On the contrary, nurse educators largely adjusted their behaviours and actions to those of others with the objective of creating shared meaning. As an essential enabler of a culture of learning within the health care workplace nurse educators used strategies such as engagement and visibility to establish identity and education service support. However, judgments of the effectiveness of these strategies were wide-ranging and dependent on differences in

expectation and the degree of surveillance adopted by others. Thus the nurse educators were both variously positioned and engaged in self-positioning to mediate expectations and achieve organisational demands. In so doing, the educators aligned their actions to others and to the social context in acting in a manner thought to be appropriate to the situation.

Yet shared meaning was not readily achieved and disruptions to the educator identity were directly linked to the perceptions of others of that role. Where perceptions varied de-valuing of nurse educators occurred. Difficulties experienced in the workplace influenced how nurse educators and other research participants viewed their professional identity and ability to construct workplace learning. These also affected the nurse educator attempts to engender a consistent sense of their role. A positioning between clinical and education practice influenced the capacity of an educator to cultivate learning and undermined a sense of identity and belonging. The role was constructed as inferior to that of a nurse unit manager by all groups except nurse educators. This situation saw nurse educators struggle to find a voice and social acceptance. Thus ambiguities in expectations combined with uncertainty in everyday work life and being viewed as the other fostered tension and power struggles as individuals and groups developed different meanings around the nurse educator role and its contribution to workplace learning.

In Chapter Six the core category *negotiating boundaries* that draws theoretical links between the categories is explained. A representation of the supporting categories is presented in Chapter Six to depict and explain the core category. Key points from analysis are considered and discussed in relation to the meanings and actions expressed with respect to the role played by the nurse educator in contributing to the continuing education needs of the nursing profession.

CHAPTER 6 – NEGOTIATING BOUNDARIES

6.1 Introduction

The research analysis generated an understanding of the social processes that shaped and reshaped the nurse educator role in a public hospital setting. The core analytical concept, *negotiating boundaries*, depicts the ways in which the social reality of the nurse educator role was formed (and reformed) within the research context. Understandings were formulated from an interpretive perspective, drawing on interactionist and constructionist concepts, to gain an appreciation of the social world of the research context (Blumer, 1969, 1998; Crotty, 1998). During the analytical process, meanings were identified, explanations developed and perceptions tested against existing knowledge to produce the constituent concepts of the core category. The focus of this chapter is the core category and theoretical propositions generated from the conceptual categories.

Initially the chapter distinguishes how the theoretical frameworks of symbolic interactionism and social constructionism locate participant construction of understanding of the experience of nurse educators. The chapter then turns to an explanation of how the underlying concepts of social constructionism (Vygotsky, 1978), negotiated order (Strauss, Schatzman, Ehrlich, Bucher & Sabshin, 1963) and structural processes (Maines, 1977), give theoretical insight into the structural and social constraints that shape nurse educator actions and their ability to resolve conflict with others. These concepts underpin a discussion of the core category, *negotiating boundaries,* as the basis for an interpretation of the role of the public hospital employed nurse educator and the implications for the role in fulfilling the continuing education needs of the profession. Finally, the chapter addresses the contextual dimensions of the research organised around the key conditions of organisation, professional identity and practice.

The research was undertaken within a broadly conceived interactionist framework with the objective of generating knowledge on how nurse educators construct meanings and understandings and thus actions within a social context. Behaviour is considered a function of both the person and the situation and thus resultant understanding relates to contextual situations which are prone to change (Mead, 1934). As such, the findings of this research indicated that neither professional identity, nor the expectations of the nurse educator role, was static but varied depending on social interaction and context. Significantly, therefore, this chapter addresses the broader context within which the nurse educator works. This chapter locates the meanings and actions explored in the previous two chapters *reflecting on attributes and expectations,* and *constructing workplace learning,* within broader social structures of which the participants may be unaware. In so doing, connections are made between the micro and macro levels of analysis and as such, between the research participants and their social worlds. In this research, it was found that while social constructions are relative they are not arbitrary and are generated through social processes that are shaped already by influences such as organisational requirements, power relationships, contexts of practice, and material resources.

Symbolic interactionism does not preclude the analysis of social structure and social organisation in addressing analytical gaps (Dennis & Martin, 2007). Similarly, social constructionism, the origins of which in part trace back to symbolic interactionism, views the world as existing as both subjective and objective reality (Berger & Luckmann, 1966). Thus, both bodies of thought support the view that knowledge "is the product of our social practices and institutions or of the interactions and negotiations between relevant social groups" (Gasper, 1999, p. 885). In other words, knowledge is sustained by social processes and hence knowledge and social processes are interrelated. Furthermore, knowledge is historically and culturally specific (Berger & Luckmann, 1966). This means that the social sphere impacts on the development of individuals in some formative way and at the same time individuals construct their meanings in response to experiences in social contexts. In this research it was found that participant construction of understanding of the experience of nurse educators reflected a continuous process of negotiation whereby the educators and the other groups sought to position the role according to varied interests within the organisation.

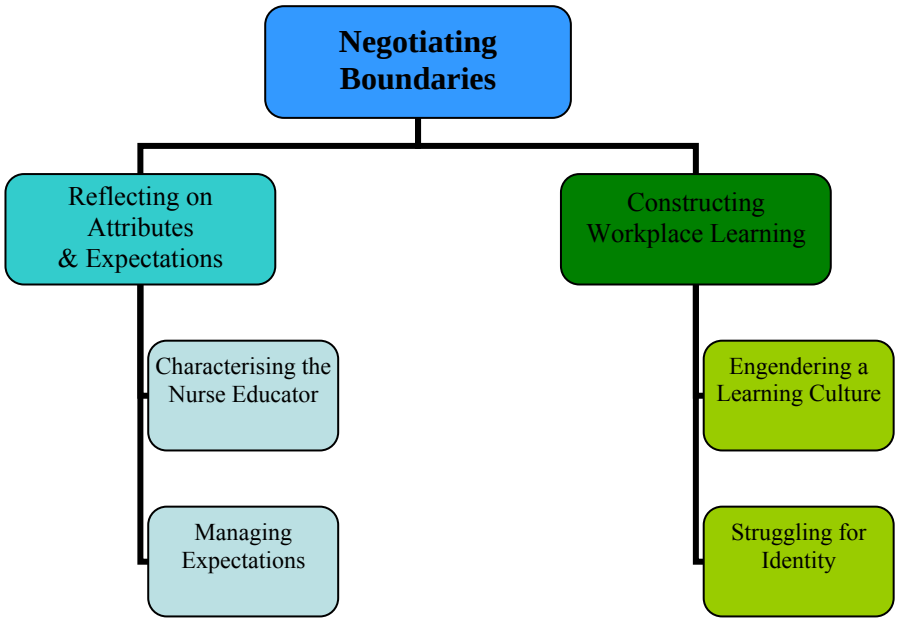
Negotiating boundaries identifies how nurse educators responded to and changed social interactions within health care work units and organisations to achieve educational service outcomes and social acceptability. Thus, ***negotiating boundaries*** was the basic socio-psychological process employed by nurse educators to manage the realities of their role. As Strauss (1978) argued, all negotiations take place within context. Hence, as identified in the earlier analytical chapters, the processes of negotiation varied according to expectations, norms, working arrangements and the mesostructure of organisational life.

6.2 Core Category – Negotiating Boundaries

In generating the core category, the researcher brought her understandings to reflect on process-oriented questions and to connect the conditions that gave rise to the complex, dynamic phenomenon. Accordingly, the core category *negotiating boundaries* presented a way of looking at the world that offers an explanation of the role of the public hospital employed nurse educator and the implications for the role in fulfilling the continuing education needs of the profession. *Negotiating boundaries* is an ongoing process which depicts the socially constructed world of the hospital employed nurse educator. The initial process involved nurse educators *reflecting on attributes and expectations* to gain an awareness of different realities. The second process *constructing workplace learning* signifies the dilemmas that nurse educators faced in engendering a culture of learning where clinical care took precedence.

The core category and supporting categories are illustrated below in Figure 6.1.

Figure 6.1: Representation of the Core Category – Negotiating Boundaries and Supporting Categories



Healthcare facilities are characterised by membership rules and social intervention by groups with differing rights, responsibilities and accountability. Hence there is much to suggest that symbolic and social differences (boundaries) defined the research setting. As such, nurse educators instigated action/interaction to negotiate these boundaries.

The negotiated order framework (Strauss et al., 1963) allows for an exploration of the structural and social constraints within which nurse educator actions were constantly being realigned. The importance of negotiated order is in the resolution of conflict and compromise. Concepts underpinning the negotiated order framework (Strauss et al., 1963) and in particular those that stress dynamic appraisal and relational negotiation processes, give insight into the ways in which social order, such as evident in a division of labour, is sustained or changed in practice. The assumption is that an organisation holds together not solely because of role structure but because its participants consciously or unconsciously construct and reconstruct order through continual negotiation of formal and informal arrangements (Maines, 1977). Thus, order is negotiated through the combination of action and

cooperation and reflects adjustments stemming from interacting participants seeking to resolve a collective problem. According to Strauss (1993), the resultant arrangements (order) are the products of negotiations and are believed to effect a 'negotiated order'. Thus, this framework offers an interactive and cultural perspective on negotiations in organisational contexts (Strauss, 1978). The process of negotiated order in this research reflects the ways in which every-day negotiated actions between the nurse educators and other groups created and recreated organisational structures and the privileging of some groups over others.

The nurse educators negotiated with others in an attempt to establish some form of order in the workplace and to engender perceptions that they were leaders in education and guardians of practice for safe patient outcomes. However, while acknowledged as crucial in constructing workplace learning and supporting the achievement of practice standards, a role attributed to the educators was as a safety net that implied a dispensability if expectations were not met. This tension between the concepts of leadership and safety net reflected the educators' position of marginality and vulnerability that was exacerbated at times of organisational re-design and/or rationalisation.

Thus, while negotiation was ongoing and pervasive throughout the research context, the kinds of negotiations, their extent and character, and the nature of limitations, also require consideration. Here it was determined that nurse educators used negotiation strategies to secure desired outcomes in response to problematic situations (boundaries) and to create a negotiated order in the workplace. Thus negotiations were at once adaptive, accommodating, reflective and tension-laden (Strauss, 1978). This process, including its constraints, was not only ongoing but was variously interpreted by other groups and this had direct implications for the public hospital nurse educator's world.

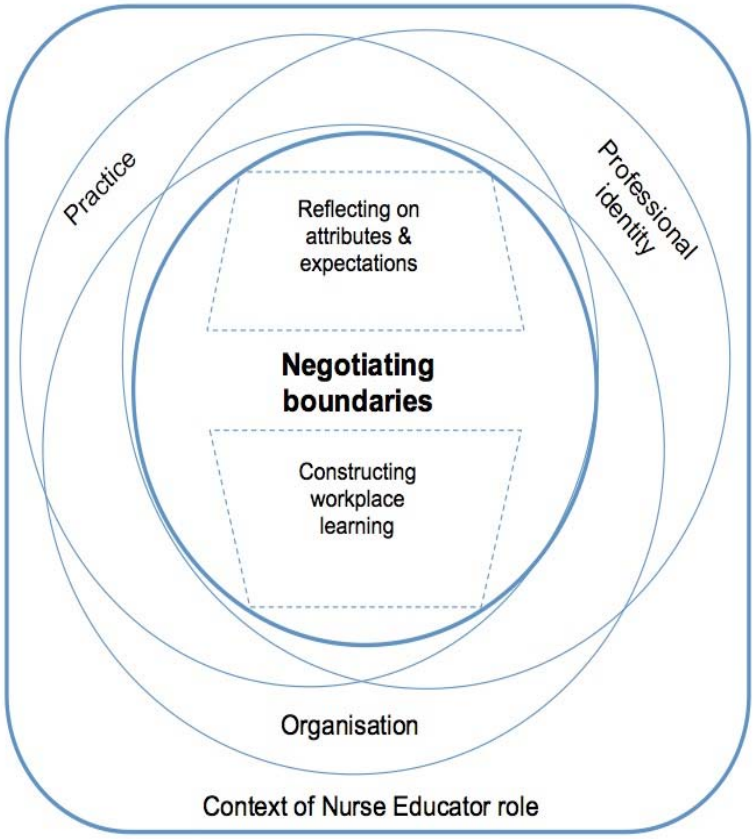
Indeed, boundaries are deemed important in distinguishing social groups or organisations from one another (Montgomery & Oliver, 2007). As Hermans and Hermans-Konopka (2010) maintain, boundaries are becoming more explicit where, because of increasing socialisation, people search for ways to connect across social and cultural practices to avoid fragmentation. Boundaries can be theorised as social

interfaces "that explore how discrepancies of organisational interests, values, power and division of labour are negotiated at critical points of linkage" (Long, 2001 p. 50). These interfaces typically emerge at the meetings of different conflicting life-worlds or areas of social interaction (Long, 2001). The aforementioned boundaries can involve discontinuities in interests, values, power and their dynamics, and require negotiation in an attempt to obtain some convergence over arrangements (Strauss, et al., 1963). Moreover, boundaries are symbolic of the socially constructed distinctions between groups that assist in providing descriptions of behaviours in an organisation (Akkerman & Bakker, 2011). As such, boundaries are important because they have a fundamental effect on organisational life and are complex, socially constructed and negotiated objects (Heracleous, 2004).

Boundaries in the research context developed from positions of difference as identified in the previous analytical chapters. Here boundaries comprised rules of inclusion and exclusion through competing expectations, the positioning of the nurse educator as outsider, and surveillance of nurse educator visibility. Social processes and relationships defined the different groups, reinforced existing social boundaries and reframed meaning (Lamont & Molnár, 2002). These key areas of symbolic and social difference (Lamont & Molnár, 2002) manifested over nurse educator role characteristics, expectations, professional relationships, values and the construction of a culture of workplace learning. The disparate views of the educator role and its contribution were also shaped by context.

Negotiations between intra-professional nursing groups are complex processes that contribute to an understanding of what takes place in the nurse educator world in health care organisations. How context and interactions and understandings produce a negotiated order and, in turn, construct an organisational structure within the social process is depicted conceptually in Figure 6.2.

Figure 6.2: Diagrammatic Representation - Negotiating Boundaries



The core category, *negotiating boundaries,* is depicted in the centre of the diagrammatic representation (Figure 6.2) and is distinguished by a relatively heavy continuous line that separates it conceptually. Within the *negotiating boundaries* space, the critical importance of the two category components central to the nurse educator role is illustrated. These two category components; *reflecting on attributes and expectations,* and *constructing workplace learning*, are distinguished by relatively light, broken lines. Line, shape and diameter have been selected to illustrate structural relationships rather than to represent relative importance or significance, and therefore their arrangement and placement to each other, are arbitrary. At any time, depending on specific circumstances, either one or a combination of the category components might be the focus. Therefore, in practice, each of these is influenced and managed with respect to how boundaries are negotiated and how actions/interactions are enacted to manage different constructed realities (Blumer, 1969).

In this conceptual frame *negotiating boundaries* explains the role and contribution of the public hospital nurse educator in place and context within the social process. While the outer line represents the contextual space of the nurse educator within the social process the three overlapping but non-concentric circles represent the three identified contextual conditions of organisation, professional identity and practice. These contextual conditions occupy much of the contextual space, but not its entirety. The unoccupied contextual space represents other potential conditions of the context which were not identified in this research.

Each component of the representation (Figure 6.2) is part of a relational process because contextual conditions (organisation, professional identity, and practice) influence the two components of the nurse-educator role (*reflecting on attributes and expectation* and *constructing workplace learning*) and capacity to negotiate meaning across different world views. Similarly negotiation of boundaries has a relational influence on contextual conditions whereby the nature and extent of negotiations occur in response to structure, actions and interactions. Actions and interactions arising from relationships shaped boundaries and accordingly the social processes that defined the nurse educator role. Thus *negotiating boundaries* is symbolic of the ways in which the participant groups redefined and shaped the boundaries of the different worlds. The following discussion is organised around the levels at which contextual constraints manifested and how they were negotiated. These levels constitute organisation, professional identity, and practice. But first, there is a consideration of context.

6.2.1 Context

Context is important and while it does not set the course of action or determine experience, it identifies the conditions in which problems and/or situations result (boundaries) and to which participants respond through action, interaction and emotion (process) (Corbin & Strauss, 2008). The complex interplay between key contextual conditions and the nurse educator role underpinned both educator contribution and interactions (process). In the words of Corbin and Strauss (2008, p. 87), context refers to:

> Structural conditions shaping the nature of situations, circumstances, or problems to which individuals respond by means of action/interaction/ emotions. Contextual conditions range from macro (e.g. social, historical, and political) to micro (those close to the individual).

In the research, the key contextual conditions were considered from the perspective of the nurse educator identity and individuals and groups with whom the educators worked; the organisation as a government administrative concern constructed for a particular purpose (healthcare); and practice which represents the work environment in which the nurse educator operates and the culture of work units. Collectively these conditions shaped the actions and interactions of the study participants and the disparate views around the nurse educator world within the public sector hospital environment.

As socially constructed organisational boundaries, contextual conditions have the capacity to constrain how nurse educators negotiate order in the workplace (Strauss et al., 1963) and fulfill a role in workplace learning. As such, contextual conditions interact with each other in varying ways, which directly (changes in engagement with people in day-to-day roles) and indirectly (organisational responses to the requirement of implementing a new service) influence the reality of the nurse educator role. Without consideration of context it is impossible to gain a clear perspective of the nurse educator role and its resultant contribution. Thus the contextual conditions of organisation, professional identity, and practice and their influence on perspectives of and within the public hospital nurse educator world are crucial in articulating the role of boundaries in socially constructing the nurse educator role.

6.2.1.1 Organisation

The nurse educator role is both shaped by and shapes the organisation in the dimensions of governance, learning and work unit environments. The inter-relationships also extend to political and strategic imperatives that align priority teaching strategies with statutory requirements and key skill sets, policies, culture, support for workplace learning, and financial controls (Conway & Elwin, 2007; Garcarz & Wilcock, 2005; Sayers & DiGiacomo, 2010; Shanley, 2004). As Conway and Elwin (2007) argue, it is difficult to understand the characteristics and problems

of current hospital based nursing education activities without reference to the organisational culture in which they exist.

In considering how the role and contribution of the nurse educator was understood in this research an appreciation of how it is situated with respect to organisational culture is relevant (Bellot, 2011). Each organisation's culture develops over time, is unique, flexible and subject to constant change (Bellot, 2011). According to Schein (1987, p. 383), organisational culture is:

> The pattern of basic assumptions which a given group has invented discovered or developed in learning to cope with its problems of external adaption and internal integration, which have worked well enough to be considered valid and therefore to be taught to new members as a correct way to perceive, think and feel in relation to those problems.

Thus organisational culture is defined and bounded by group parameters such as language, concepts, boundaries and normative criteria that provide the basis for allocating power, authority, rewards and respect (Schein, 1987). Organisational culture determines what a group pays attention to and monitors in the external environment and how it responds to the organisational environment. Thus it is not a discrete component of an organisation or readily manipulated, changed or predominantly created by managers (Willcoxson & Millett, 2000). Yet it does identify particular groups by their similarities and differences.

As has been argued (Engeström, Engeström & Kärkkäinen, 1995; Suchman, 1994), many professions including those in health care are heterogeneous in that they involve multiple individuals and groups representing different professional cultures. These authors contest that in undertaking this type of professional work boundaries and changes in negotiated order can be expected because of a high degree of specialisation and the requirement to intersect their work across organisations, disciplines and groups.

As such, sub-cultures existed within the research health care organisations (e.g. nurse educators and nurse unit managers) and changes in factors (e.g. training, rewards, power, imbalance, structure) resulted in changes in the actions of one group in terms of ongoing adaptation and only superficial changes in the other groups.

This resonates with the negotiation processes engaged in by the nurse educators where behaviour expected by others was adopted rather than consensus reached on the values of the members of the groups. In this situation, the sub-culture of nurse educators conformed to social expectations of the organisational culture and thus the prevailing negotiated order. The nurse educator modified actions and interactions to accommodate the prevalent order to reduce professional discord and gain support for the role. This was prescribed by their positioning as outsiders within clinical work units.

A further dimension of the cultural milieu was that perceptions of the value and effectiveness of the nurse educator role varied depending on the location and interests of observers. In an organisation such as a hospital, imperatives are primarily driven by clinical service demands and budget allocations. However, present-day organisations are characterised by changing, dynamic environments and thus the need for workers who are able to negotiate their specific role has become increasingly important (Ilgen & Pulakos, 1999; Smith, Ford & Kozlowski, 1997). According to Pulakos, Arad, Donovan and Plamondon (2000), the performance of those in a role will vary depending on how they deal with specific job performance dimensions such as uncertainty, interpersonal adaptability, cultural adaptability, problem solving, stress and emergency situations, unpredictability and learning work tasks.

Thus the nurse educators adopted the social identity of a group that undertakes nursing and education actions (fostering knowledge) which was distinct from those who deliver clinical care. Accordingly, the educators were situated between constructing workplace learning and care provision across multiple work units in an industry where clinical care is the focus. They reflected on the world of others and sought to connect while being held accountable in each world (Fisher & Atkinson-Gosjean, 2002). Nonetheless, the educators endured the criticism of some that they were too focused on workplace learning and not visible in the work unit. Meanwhile, others considered them educational leaders and guardians of practice standards with the ability to intellectualise and contextualise practice. The role, as a result, was not only about becoming an expert in the particular sphere of nursing education but about negotiating a space in clinical work units and being

acknowledged by managers and peers as leaders in nursing. However, at times nurse educators were also required to work as registered nurses undertaking allocated patient responsibilities or line manager delegated work which undermined their capacity to negotiate an order wherein the educator role was well defined. This exacerbated the devaluing and marginalisation of their role.

As Underwood et al. (2004) argue, professional practice and ongoing professional development are at risk in an environment driven by clinical imperatives. Requirements to meet both organisational and individual needs give rise to tension and undermines job satisfaction, workplace learning, relationships and risks nurse educator burnout (Bauder, 1982; Munro, 2008). The nurse educators cooperated with others and reframed activities, and therefore their role, to align with organisational imperatives. In so doing, the educators conformed to the social expectations of the majority as organisational imperatives often took precedence over education activities. The educators worked across the different organisational worlds of the participant groups and collaborated with those groups to mitigate constraints on being accepted. The pressure was to be all things to everyone and the result was constant negotiation in the attempt to meet educational expectations and foster engagement in workplace learning.

Higher education and national and state agencies and statutory bodies (e.g. Australian Health Practitioner Regulation Agency, Australian Nursing & Midwifery Council, Nursing and Midwifery Board of Australia, Health Workforce Australia, Health Rights Advisory Council, Health Quality and Complaints Commission) have an impact on the hospital employed nurse educator workload and role within their organisation (e.g. national requirements for twenty Continuing Professional Development points annually; scope of practice support; requisite occupational health training aligned to legislation). In reality nurse educators are unable to focus on all educational priorities at once. Education activities are always at risk of fragmentation as nurse educators deal with demands and make links between boundaries by reducing disjointedness through action and interaction (Garcarz & Wilcock, 2005).

An inability to address organisational needs will ultimately impact on the capacity of the organisation to respond, modify, and provide patient care to best practice standards with fiscal integrity. It may also have an enforcing effect on nurse educators who, as the outsiders, may not be included or may have service use reduced if differences are so great that they hinder understandings of contribution, engagement and visibility.

Yet nurse educators were required to explain, address and mitigate educational deficits in the workplace. In multiple strategic documents (Queensland Health, 1999, 2005, 2010a) and in the recommendations of a Ministerial Taskforce, Queensland Health (2007b), clinical education was emphasised as "a core function to be explicitly resourced, planned, managed and evaluated at all levels of the organisation" (Queensland Health, 2007b, p. 2). In reality, clinical services provide variable organisational support for nurse educators and for hospital based nursing education services. However, in times of organisational resource rationalisation nursing education services are often the first casualty (Davis et al., 2005; Forster, 2005). As noted in investigation of service reviews (Forster, 2005; Victorian Government, 2002), reduction of nurse educator services may result in workplace learning not adequately supported and standards of practice negatively impacted.

As an example, the Royal Melbourne Hospital Inquiry Report (Victorian Government, 2002, p. 54) identified that "nurse educators share responsibility with nurse unit managers for providing clinical supervision to nursing staff" and that "a reduction of nurse educator numbers as part of organisational restructuring had resulted in the professional development needs of clinical staff not being met at a level commensurate with their role, level of practice and responsibilities" (Victorian Government, 2002, pp. 54-55). The organisation determines workloads, role descriptions, nurse educator numbers, infrastructure and thus the extent and continuation of nursing education services. In situations such as these nurse educators may support the organisational direction even though the nurse educator group's view of the world differs. Thus nurse educators attempted to negotiate differences to ensure a peaceful co-existence and align to the identity ascribed by others so support for education services was not undermined. This is not about capitulating or being passive but it is about an understanding of reality. However, as

there is incongruity in views organisational requirements can increase workplace tension and reinforce perceptions of reduced nurse educator professional worth. The result is possible disengagement and absenteeism, which impacts on nurse educator ability to negotiate to support work place learning effectively. It also manifests in increased episodes of tension and conflict and gives rise to conversations around nurse educator value within an organisation. As such, varying degrees of cooperation and/or competition occurred between educators and others with respect to how the role and work place learning were supported. While nurse educators were able to make choices about how they engaged and negotiated, the prevailing dominance of others influenced these choices and educational service outcomes.

Constructing workplace learning in a system where clinical care takes precedence generated a certain degree of tension. Consequently, nurse educators quickly became aware of the organisational politics and how to arrange competing expectations in an endeavour to position the role as central in fostering staff development and achievement of safe practice. Nurse educators, however, do not hold the balance of power in work units. Constraints on negotiation therefore manifested as nurse educators worked to appease tension and conflict so that outcomes could be assured and the role sustained. This meant that educational outcomes, service support and collaboration were generally achieved by conforming to the socially constructed meanings of others. Hence nurse educators constantly reframed actions and actively competed with others (e.g. line managers) over role expectations in pursuit of establishing and/or maintaining standards that attracted and retained competent capable staff.

Being an outsider and lack of knowledge of role complexity also located nurse educators as vulnerable to rational economic efficiency measures. Conversely, nurse educators were also the first group asked to support staff and/or to show cause when standards and best practice outcomes were not achieved. Furthermore, irrespective of power plays others demonstrated willingness to cooperate and be guided by nurse educators when support and strategies related to risk mitigation were required.

In the current health care environment it is logical to assume that a role that straddles the boundaries of education and care will be seen as subsidiary to those who primarily provide care and manage large groups of staff. Thus, nurse educators carry great responsibility in organisations (Bauder, 1982) and yet, as noted in this research, they are attributed little decision-making power and considered an outsider. These ascribed states impacted on role acknowledgement, professional identity and subjugation.

As argued, nurse educators operate from a position of marginality. The blurred boundaries between the roles of the nurse educator and clinical nurse facilitators (RN/EN Support) reinforced this state. Where actions/interactions did not comply with social expectations the result was exclusion from decision making and work units. Actions such as exclusion and allocating nurse educator activities to clinical facilitators enhanced dissonance and reinforced the power deferential between the nurse educator and that of comparable roles.

6.2.1.2 Professional Identity

Based on social-constructivist views the concept of identity is perceived as a socially and culturally constructed self that is developed over the course of one's life through life experiences (Wenger, 2008). Thus the concept of identity refers to the conception of self as something which is constantly being re-constructed and re-negotiated in relation to experiences, situations and people with whom one acts in everyday life (Hardgraves, Miell & Macdonald, 2002; Moran & John-Steiner, 2004). Identity is therefore vital in understanding the complex, unfolding and dynamic nature between self and the organisation (Alvesson, Ashcraft & Thomas, 2008). Furthermore, the negotiation of a professional identity takes place through participation in authentic, culturally-constituted working-life contexts (Hardgraves, Miell & Macdonald, 2002). According to Wenger (1998, 2008), how a professional identity is viewed relates to the capabilities needed within a context and how these are negotiated through different means of belonging and participation. The nurse educator professional identity is therefore understood as an ongoing process of both personal and professional consideration of what it means to be a nurse educator.

Identities provide individuals with meaning and purpose, roles give structure, and organisations provide a basis for member identification (Stets & Burke, 2003). Member identification with the organisation, in turn, provides a cognitive and emotional foundation on which members build attachments and with which they create meaningful relationships with the organisation. People thus engage in forming, maintaining, strengthening or revising constructions that are productive of a sense of coherence and distinctness (Wieland, 2010). Nonetheless, as Alvesson and Willmott (2002) also point out, conscious identity work is grounded in self-doubt and contingent on inconsistencies faced in encounters with others especially when routinised construction of self-identity is challenged by aspects such as anxiety and uncertainty.

Consequently, the professional identity is complex and dynamic with ongoing modification given the complexity of the role and expectations of that role. Similarly, a nurse educator's professional identity consists of multiple sub-identities. These identities may be in conflict, especially at the time of the formation and changing of identities, and are likely to involve multivoicedness (the use of different language to different people in different contexts). As proffered by Cooper and Olson (1996), the concept of multivoicedness originates in context (sociological, historical, cultural factors) and the workplace which influences one's conception of self and sense of self as a teacher. Thus nurse educator identity formation is ever-changing and influenced by personal, professional and workplace contexts. In this research, it was noted that nurse educators demonstrated flexibility and adaptability and attempted to coordinate actions with others to gain recognition for a role that is not readily understood and to establish an acceptable professional identity.

Thus to achieve professional identity recognition the nurse educators positioned themselves in social spaces to give meaning to the role and its relationships with others. In this social space the nurse educator gained awareness of choices and in making choices the educator learned how to affirm affiliations that reinforced the nurse educator identity. Nurse educator beliefs were perpetually formed and reformed through experience and thus shaped by personal beliefs about teaching and nursing and perceptions of self and by social, occupational and organisational contexts (Kreber, 2010).

However, the educators struggled to find a voice and to make sense of their professional identity in their actions and interactions. While they competed with unit nurse managers and line managers for a professional space identity boundaries were more blurred for the educators than for the other groups. The burden of being constantly available and negotiating differing expectations was primarily the responsibility of nurse educators. This reinforced the perception of a one way process whereby nurse educators negotiated boundaries (power imbalance in work units) to address immediate clinical needs irrespective of planned activities. It was the nurse educator who modified actions to accommodate those of the perceived more powerful group. This reinforced a sense of difference between nurse educators and nurse unit and line managers. In turn, this sense of difference reinforced positions of power and created monopolies over areas of practice and knowledge both of which disrupted continuity of practice for the nurse educators.

However, the nurse educators sought to make sense of uncertain contexts in constructing professional role identity. In the rapidly changing health care environments the educators recreated professional identities. Competitive power in the form of domination by others was evident in identity creation as educators reconstructed role attributes to meet the expectations of others who held the power differential. Hence a nurse educator's negotiated identity did not always align to organisational position descriptions. This weakened the ability of nurse educators to justify and compare role application and outcomes and caused confusion for others with respect to role clarity.

Constant change thus made the development of a strong professional identity all the more complex and particularly for novice nurse educators (Beauchamp & Thomas, 2009). It was noted, for example, that novice nurse educators with a strong clinical background but little education preparation for practice struggled to construct a professional identity and to deliver educational outcomes. In conflict were the promotion of an ideal and a strained identity (Ruohotie-Lyhty, 2013). A lack of understanding of the nurse educator world restricted the novice nurse educator's ability to make sense of themselves within the role and, in turn, the ability of others to make sense of the role.

As individuals and groups are situated differently, the range of practices and interests within an organisation defines the opportunities of educators to influence workplace learning. Through practices such as communicating with colleagues (e.g. unit managers and clinical facilitators) in a particular manner, modifying behaviour to meet expectations of the role, or being visible in the work unit to reduce exclusion nurse educators negotiated a socially constituted teaching and learning space. This was a space, however, that was not readily appreciated and supported in a health care environment where clinical care was the focus. Tension existed between constructed identities and the appreciation of nurse educator identity was therefore ambiguous.

6.2.1.3 Practice

The context of practice refers to the work environment in which the nurse educator operates and the culture of that work environment. Schön (1987) referred to professional practice as a "swampy lowland area" where many decisions made in managing practice problems are based on data and knowledge that are often uncertain, ambiguous and/or hidden. In the research context, practice was inter-dependent with situational factors including the organisation, external agencies and partners (e.g. Universities, Professional Nursing Associations, Colleges and the Regulatory Authority) and internal factors such as collegiality and skill mix (Forster, 2005; Queensland Health, 2010a). External and internal factors such as staff numbers and skill mix vary between work units and influence care provided by the nurse who brings certain attributes, background and competencies to the care-giving process. For example, a nurse working in an intensive care unit needs to demonstrate advanced life support knowledge and skills as a requisite care requirement, while a nurse working in an aged care unit requires basic life support competence. The challenge is for tolerance of difference and a willingness to interact to changing contexts. The essence of what it means to be a nurse does not change but rather, the technology, the social values, science and economics all influence the knowledge, skills and abilities a nurse needs to demonstrate in their practice (Barriball et al., 1992; Clarke & Copeland, 2003).

Practice is therefore reliant on support and guidance, the systems and processes used to support success, engagement in a desire to maintain excellence, work unit politics, the demands of the work, and the required specialty skills. While

supporting staff to gain knowledge and skills was paramount, so was the necessity for effective interaction between nurse educator and clinicians. In this research, an onus to demonstrate engagement and a willingness to co-operate with others in developing nursing practice sat primarily with the nurse educators. Workplace learning was dependent on how nurse educators mediated their engagement with others and their willingness to accommodate the symbolic and socially constructed constraints that were in a constant state of change. Thus, efforts to structure a culture of learning were undermined where interests did not converge. Nurse educators were both leaders in education in the workplace and a safety net resource for others. However being positioned as the other often stymied ability to demonstrate leadership effectiveness particularly when support for the role was susceptible to competitive power relationship, process re-design and other economic-based measures irrespective of practice need.

According to O'Brien-Pallas, Tomblin Murphy, Baumann, and Birch (2001) when people, resources and/or structures are lacking, there is conflict between the nurse's professional responsibility and the provision of adequate best-practice patient care. As the International Council of Nurses (2007, p. 22) advocates a "climate of learning sets the stage for a positive and safe work environment/organisation", and encourages "lifelong learning by supporting professional development, mutual sharing of knowledge and investing time, effort, and resources" to enhance the practice of their employees' knowledge, skills, and judgment.

While nurse educators were perceived as the guardians of practice standards and facilitators of staff capacity how the role was supported and enacted varied across practice settings. Practice context shapes the capacity of the nurse educator to contribute. As noted, to accommodate the social expectations of the organisational culture and thus the prevailing negotiated order, nurse educators realigned and adjusted their actions/interactions. However, some educational programs are standardised, with pre-determined teaching strategies, performance indicators and outcomes linked to legislation and policy. These skill-acquisition programs are imposed as a result of legislation (e.g. Workplace Health and Safety) or directives of an organisation. This meant that nurse educators at times lacked the

power and control to challenge practices where parameters were determined and dominated by others (DeMarco & Roberts, 2003; Roberts, DeMarco & Griffin, 2009; Sheridan-Leos, 2008). While a focus on how power struggles between vested interests has a decisive impact on what policies are implemented this is by no means a foregone conclusion. As observed in this research, nurse educators attempted to negotiate best educational and practice outcomes through modification of actions and interaction and co-operation to accommodate the dominate view. However, when the dominant view in a work unit impeded achievement of standard criteria, as acknowledged guardians of standards nurse educators were not averse to exerting different influences such as reference to legislation and policies and obtaining line manager involvement to mitigate practice risk and restore relative order.

Power assumed an important role in negotiated processes where mediation over points of difference was not easy as the actions of the educators were restricted by rules and the division of labour. As a result of the positioning of power, some nurse managers exercised the right to monitor and supervise nurse education interaction and their access to knowledge of events in the work units. Thus situations arose where others had symbolic power over the educators even though not officially sanctioned by organisational rules or policies. Furthermore, the form of interaction emphasised the 'otherness' of the role, highlighted its marginality and the lack of understanding of its complexity within specific organisational/work unit contexts. It also pinpointed the unwillingness of some to acknowledge monopolies over practice and to tolerate and respect differences of other individuals and groups.

Competitive power between nurse educators and others (e.g. nurse unit managers) caused points of difference, reduced interaction and emphasised nurse educator marginality. However, as previously acknowledged, negotiation by nurse educators also enables them to use power tactically at times to achieve desired outcomes (Nugus, Greenfoeld, Travaglis, Westbrook & Braithwaite; 2010). Here it was noted that in situations such as patient or staff safety collaboration between groups was mutually undertaken to recreate relatively stable order within the context of practice. This situation typifies the way power is negotiated and engaged to maximise contributions between individuals and groups to achieve relative order and best practice outcomes within the workplace (Nugus et al., 2010).

Differences in views over nurse educator role flexibility, visibility and engagement in clinical work units and perceptions of territorial tensions created confusion between nursing groups and disparate expectations. Hauss and Engeström (2000) assert that tensions and conflicts in a workplace may represent structural inconsistencies within or between activity and organisational systems. It can be destructive to educational achievement, or potentially productive, when seeking organisational transformation (Hauss & Engeström, 2000). Individuals look for balance between stability and transition and between what is known and what is sought (Marienau & Chickering, 1982). Socially constituted perceptions between the intra-professional groups of this research influenced individual and group involvement. Nurse educators demonstrated role flexibility and an ability to navigate changing conditions across organisational and work environment contexts and address points of difference. However, a consequence of flexibility of role and constant negotiations is reduced education outcomes.

The functioning of nurse educators predominately within the territory of others (e.g. nurse unit manager) meant that often they were not fully conversant about work unit needs. As such, they were treated differently from work unit staff. Negotiating across work units to support achievement of practice standards and safe patient care also restricted nurse educator interactions with staff and limited the possibilities of continuing education. Nonetheless, while performance in the nurse educator role varied, what did not fluctuate was acknowledgment that nurse educators facilitated workplace learning. But how nurse educators negotiated order with respect to practice could be changed at any time by others (e.g. line managers) and thus opposition occurred when educators implemented changes that were not popular in clinical work units. Hence these experiences of nurse educators have implications for managing role boundaries and make division of labour for this group extremely difficult to sustain within different workplace contexts.

As identified in the findings of this research and argued elsewhere (Conway & Elwin, 2007; Hughes, 2005; Lepine & Ahola-Sidaway, 2000; Ramage, 2004; Ridge, 2005; Sayers et al., 2011) the nurse educator role is complex and difficult to measure. Nonetheless, as this research determined, the role is perceived as fundamentally leading education in the workplace through actions and interactions

that link theory to practice. Complex environments with competing demands (Bellack, 2005; Conway & Elwin, 2007; Levitt-Jones, 2005) mean that nurse educators are in a position that is simultaneously crucial to the maintenance of safe practice and vulnerable in being perceived as the resource of last resort in the clinical work units. Such actions are manifest in the tradition of professional activities and practice standards even where time, relationships, power struggles, workloads and variable staff interest may challenge those actions. If actions/interactions are seen to be of value staff will engage and the nurse educator will be viewed as contributing effectively (Corbin & Strauss, 2008).

Nurse educators invested in accommodating the needs, desires and expectations of others and conforming to the organisational culture and thus the prevailing negotiated order. This required them to move beyond Schön's (1987) assertion that managing practice is based on little knowledge, data or ambiguous decision making. How different and competing context demands are negotiated to establish links between groups depends on how reality is socially constructed, the past experience of actors and interpretations of the world and individual meanings (Blumer, 1969). An educator's ability to mediate their actions/interactions and emotions in an attempt to maintain a balance between context elements was important since imbalance in any one context could undermine the educator role, education service outcomes, and care quality.

Engagement with and perceptions of the value and effectiveness of the nurse educator role varied depending on the locations and interests of observers. On one hand they had a very rich and valuable position since they were viewed as leaders who constructed workplace learning, initiated change in clinical work units and maintained and set practice standards. On the other hand nurse educators faced the difficult position of being viewed as the other in clinical work units and risked never fully belonging or having the full extent of their role acknowledged. Hence nurse educators negotiated on sites of difference between groups (e.g. differing expectations of the role and views of value) to maintain and/or restore order and thus obtain support for their role and education activities. Effective support facilitates building capacity in nursing staff to meet practice standards and the provision of safe care.

6.2.2 Summary

Organisational boundaries and contextual conditions both influenced and constrained how nurse educators negotiated order in the workplace and fulfilled a role in workplace learning. In the current research power and associated interests positioned workplace learning as socially constituted and contested. Thus, as a lead advocate of workplace learning for nursing in a health care facility, the role and contribution of the nurse educator was similarly contested. Nurse educators were influenced by a changing environment and this demanded on-going self-evaluation and negotiation if any semblance of order was to be created. However, the educators alone could not compel action and a great deal of negotiation was required to satisfy the diverse interests of others within the health care facilities. While negotiation may reduce boundaries it will not be effective if boundaries are not recognised and socially constructed indicators defining a group's membership and territory are not clear (Akkerman & Bakker, 2011; Montgomery & Oliver, 2007: Walker & Nocon, 2007). Nurse educators managed the position of being a nexus between the differing worlds of clinical practice and education by negotiating with others in an attempt to establish relative order in the workplace and to engender perceptions that they were leaders in education and guardians of practice standards. However, it was noted that where there were too many conflicting expectations and processes for the nurse educator to negotiate, and where expectations continually changed based on individual rather than role expectations, the role became less effective and more marginalised. Thus, given the role was constructed as a safety net that straddled the boundaries of care and education, capacity to influence the actions and interactions of others depended upon the degree of otherness attributed to the educators and resultant degree of marginality.

A nurse educator continuously redefines and re-shapes boundary meaning/s (e.g. how they and others view role attributes and differing expectations). The greater the degree of contrast between role identities the greater potential for role blurring and the degree of negotiation required (Ashforth, Kreiner & Fugate, 2000). In this study, it was determined that nurse educators mediated multiple roles in contexts of varying expectations. Consequently, it is argued that nurse educators engage in negotiation processes within uncertain day-to-day work environments. The outcome of these negotiations influences how educators interpret and communicate ways of working (Strauss, 1978). Thus it is noted that perceptions of

role value and effectiveness varied depending on the location and interests of observers. Consequently nurse educators faced ongoing pressure to be all things to all people. This unrealistic impression necessitated constant negotiation to accommodate expectations thereby creating monopolies over areas of practice and knowledge which disrupted continuity of practice of nurse educators.

The nurse educators adopted the social identity of a group that fosters knowledge (nursing education actions) which was distinct from those who delivered care. Nurse educator identity was thus dynamic and influenced by personal, professional and workplace contexts which are in a constant state of flux. Furthermore, educator beliefs were formed and reformed through experience and shaped by beliefs about teaching and nursing and perceptions of self which in turn were influenced by social, occupational and organisational contexts. However, as noted in this research, given variation in expectations, otherness and marginality in work units the nurse educators often struggled to make sense of their professional identity in their actions and interactions.

The ability of the nurse educator to reflect on their actions and/or interactions and practices is an important process as it assists in recognition and clarification of differences between perceptions of observers (Akkerman & Bakker, 2011; Montgomery & Oliver, 2007). Thus the nurse educator by and large considers restrictions and limitations placed on the role and then looks at themselves through the eyes of the world of the other group and attempts to communicate with the other/s to change actions or perceptions (e.g. increasing visibility in a clinical unit to align with nurse unit manager perceptions of 'being on the floor'). This action is undertaken to assist in expanding perspectives and forming a new view of the nurse educator role, value and the way they work and interact with others to meet expectations and reduce ambiguity and marginality. Thus a positive learning process for those involved (e.g. line managers, peers and work unit staff) should be achieved as boundaries are challenged and new meaning accomplished and actions undertaken as part of a process for establishing continuity in a situation of reduction in sociocultural difference (Akkerman & Bakker, 2011). Thus in this research, for functionality reasons in most situations nurse educators negotiated their actions/interactions to behave as expected by the majority to remain connected and coexist rather than necessarily agreeing with the actions and values of the other

intra-professional nursing groups. The burden of being constantly available and negotiating differing expectations was primarily the responsibility of nurse educators, who generally modified actions to accommodate those of the perceived more powerful group.

Hence, in this research it was noted that nurse educators negotiated points of difference to facilitate achievement of shared meanings to assist staff to achieve practice standards and patient outcomes. Thus they reflected on and interpreted behaviours, actions and emotions to accommodate the expectations of the majority. However, this required effective application of different negotiation skills, participation in power struggles, political insight, flexibility in work practices and an ability to respond to changing stakeholder expectations. Irrespective of nurse educator flexibility and ability to negotiate differing realities impacting on educator identity, application of the role and ability to support others and contribute were noted as influencing factors on outcomes achieved.

While affirmations of the need for hospital employed educators and the expectations of a nurse educator to adapt to changing workplace contexts were noted in this research, so too was variation in committed effort by others to support the nurse educator role and construct a culture of workplace learning. *Negotiating boundaries* provides insight into how nurse educators move between and prioritise their multiple roles and organise their work in the organisational context for both themselves and the others with whom they work. To foster enhanced appreciation of the role requires revisiting the beliefs of intra-professional nursing groups and coaching them about how nurse educators negotiate boundaries to achieve order in the work environment. It will also involve these groups developing a better appreciation of the value and world views of each.

6.3 Situating the Core Category.

The aim of this research was to explore, analyse and generate an understanding of the role and contribution of the public sector hospital employed nurse educator in Queensland. *Negotiating boundaries* was constructed as the core category and explains the structural and social constraints within which nurse educator actions are constantly being realigned and negotiated to gain an

appreciation of study participants shared meanings of the social worlds of the public hospital nurse educator and the implication for its contribution to the continuing needs of the profession.

In accordance with Strauss and Corbin's (1988) advice to return to the literature related to specific findings in order to supplement data, during the latter stages of data collection and analysis, the literature was reviewed to contextualise the findings with respect to existing knowledge (Smith & Biley, 1997; Strauss & Corbin, 1998). Findings generated from the data were compared with literature as data, using the constant comparative method of analysis, an approach which did not constrain analytic conceptualisation of original data (Strauss & Corbin, 1998). Accordingly, in integrating and contextualising the core category interview data analysis, literature as data and theory were assimilated into an overarching analytical discussion.

The contextual conditions discussed in the present study (organisation, professional identity and practice) differ from previous Australian studies which focused on factors enhancing and constraining role development, such as barriers to the role, lack of defined career pathway, professional development support, student nurse facilitation and health policy (Conway & Elwin, 2007; Sayers & DiGiacomo, 2010). There are different practice standards, requirements, and organisational imperatives too, and these therefore influence role application, facilitation strategies, the nature of workplace learning and desired outcomes.

No published literature was uncovered that specifically addressed the nurse educator role in public sector health settings as *negotiating boundaries* between the intra-professional nursing groups with whom they work to enable a complex role to be effective and appreciated in constructing workplace learning. In summary, reconsidering the literature in respect to the world of the hospital employed nurse educator suggests there is scare theoretical understanding of the topic.

A grounded theory study undertaken by Ramage (2004) in the UK found that link teachers who work between universities and hospitals to support staff undertaking programs of study (e.g. student learning during placements) negotiate

multiple roles. Ramage (2004, p. 293) identified that although the focus of the study was 'link teachers,' similar experiences could translate to nurse academics, practice educators and clinical facilitators. In the current study negotiating the role of the nurse educator so that it was accepted and supported by others within the workplace was central, rather than negotiating multiple aspects required to transition into the role as was the focus of Ramage's (2004) study. While some similarities to Ramage's (2004) findings are acknowledged and have been reported, her study was undertaken in a different context and the focus did not include the perspective of those other than link teachers. This role is different from the nurse educator focus of this study which also has sought the views of nurses outside hospital employed nurse educator services.

Subsequent review of the published literature reveals that the theoretical understanding *negotiating boundaries* presented in this study has links to the negotiated order framework (Strauss et al., 1963). This framework offers an interactive and cultural perspective on negotiations in organisational contexts (Strauss, 1978). Hence throughout the explanation of *negotiating boundaries* the tenets of negotiated order (Strauss et al., 1963) have been used to illustrate how everyday negotiated actions between nurse educators and intra-professional nursing groups provided views of social worlds and create and recreate organisational structures, privileging some groups over others (Strauss, 1978).

Additionally, the notion of 'boundary crossing' (Akkerman & Bakker, 2011; Hauss and Engeström, 2000, Heracleous, 2004; Hermans and Hermans-Konopka, 2010; Lamont & Molnár, 2002; Montgomery & Oliver, 2007) was also applied to the theoretical understanding of *negotiating boundaries.* The notion of 'boundary crossing' was introduced more than twenty years ago with respect to organisational and management studies and education research. Boundaries of practices denote how professionals at work enter unfamiliar territory which reduces their expertise to some degree (Suchman, 1994, p. 25) and how they negotiate challenges from different contexts to achieve 'hybrid situations' (Engeström, Engeström & Kärkkäinen, 1995, p. 319). In this respect boundaries refer to discontinuities and separation between the inside and outside a community that allow or hinder outsider entry to the community (Wenger, 1998, p.120).

The theoretical framework underlying boundary theory focuses on the process of individuals' micro role transitions between roles (Ashforth, Kreiner & Fugate, 2000). Within each realm individuals build boundaries around their roles, with each role boundary indicating the scope of a particular role (Ashforth et al., 2000). Overall, boundary theory examines the choices individuals make in entering roles by overcoming boundaries and delimiting the scope of the role (Ashforth et al., 2000; King, Felin & Whetten, 2010). According to Lynch (2007) boundary work literature focuses primarily on strategies and practices that groups use to construct collective identities.

Therefore, while the concept of crossing boundaries is deemed to have some similarity with the theoretical understanding of this study, there are also differences. However, where relevant, similar evidence from the literature has been acknowledged and recorded to support the discussion. Support includes the perspective that boundaries are crucial for analysing how actors construct groups and how this shapes their understanding of their responsibilities towards these groups (Lamont & Molnár, 2002). The stance that the work of some professionals can embody different professional cultures has also been considered (Engeström et al., 1995).

However, the theoretical understanding of *negotiating boundaries* in this study is not about the nature of role transition (e.g. nurse educator to nurse unit manager) from one role to the next and assuming the characteristics of a new role. It is about how hospital employed nurse educators construct and reconstruct order, continually negotiating formal and informal arrangements among those with whom they work and within the organisation. Thus it explains how and why nurse educators use strategies in response to problematic situations (boundaries) in an attempt to maintain a negotiated order in the workplace.

6.4 Conclusion

The theoretical understanding *negotiating boundaries* was generated from conceptual categories not found in the published literature in the form of how it is explained with respect to the study focus. *Negotiating boundaries* encapsulates how nurse educators act as workplace resources that contribute to continuing education

and a culture of learning. Nurse educators seek to link differing worlds to facilitate workplace development opportunities for nursing staff to assist them to achieve practice standards and best practice patient outcomes.

This theoretical understanding explains how nurse educators negotiate social and symbolic boundaries to establish order and gain acceptance. Thus they lead construction of a culture of learning in the workplace, and as a resource safety net advocate for achievement of standards within health care organisations. To achieve this requires consideration of context conditions and their influence on the nurse educator's ability to negotiate order. The theoretical understanding provides an insight into how nurse educators move between and prioritise their multiple roles, and organise their work in an organisational context for both the benefit of themselves and those with whom they work.

To illustrate how everyday negotiated actions between nurse educators and different groups create and recreate organisational structures the tenets of the social constructivism and negotiated order (Strauss et al., 1963) were used to gain insight into the reality of the hospital employed nurse educator world. These assisted in examination of patterned negotiation strategies that occurred when there were discontinuities between the social worlds of nurse educators and other participant groups.

Negotiating boundaries in a hospital environment is not easy and requires negotiation skills, participation in power struggles, political insight, flexibility in work practices and an ability to respond to changing stakeholder expectations and maintain coexistence. Issues of impact, role clarity, visibility and otherness in clinical contexts require ongoing work. Nurse educators act as an adaptable and tolerant workplace resource that reflects on behaviours, actions and emotions and modifies these to accommodate organisational culture and thus the prevailing negotiated order.

Chapter Seven addresses concluding points around the research findings, articulates implications for practice, limitations and recommendations, reflects upon lessons learned and explores possibilities for further research in the area.

CHAPTER 7 – CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

7.1 Introduction

This research explored the socially constructed meanings around the role and contribution of the hospital employed nurse educator and generated theoretical constructs that give greater insight into this role. Similarities and differences to existing literature were considered informed by "selectivity according to perceived areas of relevance" (Guthrie, 2000, p. 101). As such, the manner, significance, implications, and recommendations arising from the research relate directly to the nurse educator role and future research. This chapter concludes the study in revisiting the research aims and considers the implications and limitations of the methodological approach to the study. Finally, the chapter considers future research and recommendations arising from the study as they relate to the role and contribution of the hospital employed nurse educator, nursing practice and policy.

Findings of this study provide a basis for further research in particular because this research is the first known study of its type in Queensland and Australia. The research makes a significant contribution to the area in terms of insight into the role and work context of the hospital employed nurse educator and proposes *negotiating boundaries* as a theoretical construct that explains how hospital employed nurse educators enact the role and contribute to practice.

7.2 A Summary of the Research

The present research contributes to role clarification in the face of the evidence of confusion regarding the role of nurse educator (Christiansen, 2011; Conway & Elwin, 2007; Queensland Health, 2010a; Sayers & DiGiacomo, 2010). Nursing education roles are identified as fundamental in supporting both inexperienced and experienced nurses to apply learning to clinical practice; however there is uncertainty as to who should take the lead role for continuing education (Conway & Elwin, 2007; Gallagher, 2007; McCormack & Slater, 2006; Queensland Health, 2010a). Blurring of role boundaries and responsibilities exists across the different classifications of nurses who contribute to the continuing professional development of nursing staff (Conway & Elwin, 2007; Queensland Health, 2010a).

Further, discrepancy in nomenclature such as 'clinical nurse educator', 'clinical facilitator', 'staff development educator' and 'nurse educator' across Australian states and between countries, contributes to ambiguity in role comparison, clarity and enactment (Christiansen, 2011; Conway & Elwin, 2007; Queensland Health, 2010a).

The purpose of this research was to explore perceptions of different classifications of nursing staff (clinicians, line managers and nurse educators) to obtain a view of the constructed meaning of the role and contribution of the public sector hospital employed nurse educator. The intent was to generate an in-depth theoretical understanding that better clarifies the role and its contribution rather than a description of the experience.

The theoretical basis for the study lies within an interpretive perspective (Blumer, 1969; 1998; Crotty, 1998). The theoretical framework of symbolic interactionism was chosen to underpin this research because of its focus on understanding how participant behaviours have been shaped through social interaction and interpretations within a particular context (Blumer, 1969; Goffman, 1963; Mead, 1934; Milliken & Schreiber, 2001). Such an approach allowed the researcher to determine meanings attributed to the role of the hospital employed nurse educator within the context of the workplace according to understandings attributed by different intra-professional nursing groups. This theoretical perspective, based on a central tenet of generation of meaning and its interpretation, supports research such as this that focuses on human interactions within a specific professional context (Blumer, 1969). As such, symbolic interactionism allowed the researcher to explore the process of meaning making associated with the contributions of nurse educators and also contributed to the discovery and appreciation of patterned meanings and behaviours within and between the research groups. While a number of variations of symbolic interactionism have evolved over time, the work originating from the Chicago School with its foundation in the pragmatist philosophies has been most prominent and is applied in this research (Farganis, 2011). Where theoretically relevant, the postulations of Erving Goffman (1963, 1969, 1971) were also drawn upon.

Grounded theory was considered an appropriate method for this research because of its ability to generate theory regarding patterns of behaviour within a substantive setting especially as there is little existing formal knowledge of the research topic, particularly in the Australian context. Grounded theory is compatible with the theoretical perspective of symbolic interactionism in the sense that it encourages the determination of research outcomes that explain the meaning of complex social interactions and facilitates understanding of socially constructed meaning from the perspective of a given time and context (Annells, 1997; Chenitz & Swanson, 1986; Corbin & Strauss, 2008; Martin & Turner, 1986). Strauss and Corbin's (1998) grounded theory method was applied as this method supports the perspective there is no 'one reality' waiting to be discovered (Corbin & Strauss, 2008) and that the researcher brings a range of resources to data interpretation and as such is actively involved in constructing theory. The Straussian approach (Corbin & Strauss, 2008; Strauss & Corbin, 1998) offered the researcher a framework that assigns a focus on conditions, actions/interactions and consequences. The theoretical and epistemological underpinnings of the research allowed the application of diverse methods for gathering rich data.

Consideration of the wide geographical distribution of nurse educators working in Australia led to a pragmatic decision to focus the research on the Queensland geographic context. Purposive and theoretical sampling was used, and the main source of data was fifty-five (55) in-depth interviews with members of four professionally homogenous groups. Each of the four sample groups was chosen because each could bring to the research an understanding of the needs and knowledge of the members of each group relevant to the role of the nurse educator. Initial data collection and analysis from each of the four sample groups directed further choices and progression to theoretical sampling. The interview data were generated through language, interactions and meanings of the participants over a seven-month period until it was considered that the point of theoretical sufficiency had been reached. During interviews notes were made to record details of observations and concerns. Within twenty-four hours of each interview a verbatim transcription was produced. In addition, the researcher used memos and notations of reflections to capture thoughts, impressions, issues to follow up, and conclusions generated during the research process. Relevant documents were used to assist in collaborating and augmenting evidence, and in developing relevant insights.

Furthermore, literature was accessed as data to address issues arising during analysis.

Once analysis of the data was completed, theoretical writing commenced. This process, viewed as joining the findings together into a scholarly account, involved using the collated memos for each category and determining the 'core category'. Ultimately, two major categories were generated from experiences and meaning expressed in participant interview data.

The generated core category *negotiating boundaries* presents a way of looking at the world that offers an explanation of the role of the public hospital employed nurse educator and the implications for the role in fulfilling the continuing education needs of the profession. Thus *negotiating boundaries* is an ongoing process which forms part of the socially constructed world of the hospital employed nurse educator. The initial process involved nurse educators *reflecting on attributes and expectations* to gain an awareness of different realities. The second process *constructing workplace learning* signifies the dilemmas that nurse educators faced in engendering a culture of learning where clinical care takes precedence.

In Chapter Four, the category *reflecting on attributes and expectation*s captured participant perceptions of the role attributes of public sector employed nurse educators. The role and how the boundaries that the nurse educators encountered influenced both their actions and the outcomes they achieved were considered within this category and the two resulting sub-categories *characterizing the nurse educator* and *managing expectations*. Here it was argued that conflicting views on what is expected of the nurse educator were located with the context of nurse education services. While differing views on the expectations of the hospital employed nurse educator role within the context of nurse education services persisted, the prevailing view was that the educator position was highly valued. However, although reference was made to skills including capacity building, fostering of inquiry, and support for practice standards, the role of educator was fundamentally viewed as a safety net. How the value of the role was conceived therefore was shaped, not by the full extent and nature of the nurse educator role, but by its contextual meaning. Role blurring, erosion, confusing nomenclature, de-

valuing and variation in professional relationships were found to have noted as impacted negatively on nurse educator role enactment, job satisfaction and value The absence of an acknowledgement of the complexity of the position did not diminish expectations that nurse educators should be all things to all people. This perception reinforced the view that the hospital employed nurse educator position was multifaceted, difficult to describe, poorly understood and not measured easily in terms of direct causal effect outcomes.

Shared meanings and consideration of differences within symbolic boundaries reinforced perceptions of the nurse educator as a safety net resource, gate keeper, trouble shooter and facilitator of a learning culture in workplace units and across facilities. However, interactions between individuals and groups impacted on the ability of the nurse educator to fulfill these roles.

The second category, *constructing workplace learning,* was addressed in Chapter Five. This category reflects participant perceptions around educational focus, requirements and processes applied in workplace learning. Underpinning the category *constructing workplace learning* was a conceptualisation of the nurse educator as an essential feature of workplace learning. The understanding was that the nurse educator was a facilitator of learning and constructed a culture of learning in workplace units and/or across facilities. Nonetheless, in practice nurse educators experienced political and power tensions whereby they were unable to establish and maintain supportive relationships, meet expectations, or develop and use systems and processes to advantage.

Where meanings were not shared role conflict was the result and disruptions to the educator identity were directly linked to the perceptions of others of that role. Meanings constructed around the nurse educator role were often contested and this gave rise to difficulties for educators in making the role their own. On the contrary, nurse educators largely adjusted their behaviours and actions to those of others in an attempt to create shared meaning. The nurse educators used strategies such as engagement and visibility to establish identity and education service support. Thus the nurse educators were both variously positioned and engaged in self-positioning to mediate expectations and achieve organisational demands. In so doing, the

educators aligned their actions to others and to the social context in acting in a manner thought to be appropriate to the situation.

Nurse educators considered that they faced ongoing difficulties, particularly because the role was largely defined by being as they were expected to be all things to everybody as an aspect of their role. Yet this positioned the nurse educator more as a 'safety net' than a leader who changes workplace practices through education activities. These conflicting views often located the nurse educator at odds with the nurse unit manager and others over work unit priorities and nurse educator value. Being considered the other, or as a peripheral work unit resource, made problematic the construction of an educator identity and negatively influenced the nurse educators' capacity to negotiate social relationships and views of role value. Consequently it was the nurse educator who modified behaviour and actions in an attempt to meet expectations to engender effective workplace learning and acceptance in work units and the organisation.

Chapter Six constituted an explanation of how the theoretical understanding underpinning *negotiating boundaries* offers an explanation of the role of the public hospital employed nurse educator and the implications for the role in fulfilling the continuing education needs of the profession. This core analytical concept depicts the ways in which the social reality of the nurse educator role was formed (and reformed) within the research context. Understandings were formulated from an interpretive perspective, drawing on interactionist and constructionist concepts, to gain an appreciation of the social world of the research context. Two categories underpinning the core category formed the building blocks that supported the theoretical analysis. How the underlying concepts of the negotiated order framework assisted in addressing structural and social constraints impacting on nurse educator actions and their ability to resolve conflict with others was also examined. Negotiation was a central and widespread social process in the research. Negotiation was also grounded in the political realities of research context. Examination of patterned negotiation strategies that manifested where there were discontinuities between the nurse educators and other participant groups then turned to the contextual dimensions of the research situation organised around the key conditions of organisation, professional identity and practice.

Boundaries in this research context developed from positions of difference as identified in analytical Chapters Four and Five. Differences in social processes and relationships between intra-professional groups were evident that both maintained existing social boundaries and were used to reframe meaning (Lamont & Molnár, 2002). These key areas of symbolic and social difference (Lamont & Molnár, 2002) related to nurse educator role characteristics, expectations, relationships formed, views of value and construction of a culture of workplace learning. The main boundaries comprised rules of inclusion and exclusion through competing expectations, the positioning of the nurse educator as outsider, and surveillance of nurse educator visibility. The disparate views of the educator role and its contribution were thus shaped by context and formal organisational structure. This meant that nurse educator negotiations assumed different forms as determined by the combination of social interactions and organisational structure (Maines, 1997; Strauss, 1978). Negotiations between the intra-professional nursing groups were complex processes that contributed to an understanding of what takes place in the nurse educator world in health care organisations.

This research found that *negotiating boundaries* in a hospital environment was characteristic of the role and problematic, for is not an easy feat for the work of nurse educators. It required negotiation skills, participation in power struggles, political insight, flexibility in work practices and adaptation to an ability to respond to changing stakeholder expectations and maintain coexistence within different workplace contextual conditions. Despite the impacts of views of role value, visibility and being deemed the 'other' in *negotiating boundaries* nurse educators were found to act as an adaptable and tolerant workplace resource who reflects on, and interprets their behaviours, actions and emotions to accommodate the expectations of the majority. While accommodation evoked more positive social relations it also reinforced the *otherness* of the educator role in constructing their role to contribute to continuing education and a culture of workplace learning.

7.3 Achievement of Research Aim

The aim of this research was to examine nurse educators within one state of Australia using interpretative methodology informed by the assumptions of symbolic interactionism. Theoretical propositions generated from analysis were 'grounded' in relevant data thereby allowing for interpretation of the phenomenon in ways that gave respect to the data (Strauss & Corbin, 1998). The meanings given to events, actions, interactions, and emotions expressed in response, and within the context of responses and events are revealed by this research study (Corbin & Strauss, 2008). One of the contributions of this study was to add knowledge about the public hospital nurse educator. As such, the research generated a theoretical understanding of the process of *negotiating boundaries* that captured the patterns of meanings surrounding the role and contribution of the nurse educator in Queensland. This theoretical understanding explains how nurse educators negotiated social and symbolic boundaries to establish order by which they were accepted and valued in the role of constructing a culture of workplace learning. It also points to ways in which the current health care structure positions the nurse educator as a resource safety net. The coexistence of collaboration and competitive power reflects the inter-professional relationships in the research context and suggests the need for greater integration of nurse education in health care. Thus the research adds to the existing body of knowledge of hospital employed nurse educators in Australia and increases the confidence with which this knowledge is regarded.

A review of published literature in pursuit of the research aim found variance in the use of *nurse educator* as a generic term and little qualification for differing roles and positions including undergraduate student support, industry-employed staff supporting workplace learning and continuing professional development, and academic and vocational positions (Clifford, 1992; Conway & Elwin, 2007; Sayers & DiGiacomo, 2010; Ramage, 2004; Swihart, 2009). This realisation is important to understanding and explaining tensions surrounding the educator role.

Nurse educator activities occur in the health care environment where clinical care takes precedence and where the nurse educator fulfills multiple competing roles. Through actions and interactions the hospital employed nurse educator negotiates discontinuities in perceptions to enable them to function as a key workplace 'safety net' resource. However, there are times when this is subject to variable support, expectations and attributed value causing tension and power plays amongst intra-professional nursing groups. The nature of nurse educator negotiations therefore, vary and take place under different circumstances as the extent of their negotiations are shaped and directed by social organisational structure. Although the hospital employed nurse educator role was considered the essential lead in constructing workplace learning and in upholding practice standards meaning attributed such as, resource 'safety net' also situates the role in a state of marginality. Hence hospital nurse educators are positioned at a disadvantage as they are considered an 'other', and thus encounter boundaries related to inclusion, perceptions of role value, visibility and power plays. Irrespective of these factors the hospital employed nurse educator was found to negotiate with intra-professional nursing groups and individuals to support achievement of educational outcomes and foster a culture of learning. Negotiation was undertaken to accommodate the socially accepted meaning of the role in order to demonstrate sound knowledge of education principles and their application in the workplace, and to exhibit rigorous workplace and professional knowledge and skills as criteria for assuming the key responsibility in constructing workplace learning. Thus nurse educators were found to contribute to all facets of practice including practice standards in an effective manner by negotiating order in the workplace. Meaning expressed was that if there were no hospital employed nurse educators, or a significant reduction in their numbers the culture of workplace leaning, engagement in professional pursuits and standards of practice would conceivably decrease due to competing workplace demands and lack of a culture of independent responsibility for personal development.

7.4 Implications

In addressing the research question, the current research makes a significant contribution towards redressing a lack of knowledge of the role in ways that can influence and shape the future role in the workplace. Expectations, professional relationships and perceptions that underpin inequities, devaluing, bullying and conflicting work demands all highlight contextual and professional tension and conflict in need of resolution. The study supports anecdotal and limited empirical evidence of the existence of confusion around the role, and of a complex interplay between the organisation, professional identity and practice.

The findings of this research have implications for nurse leaders at all levels and highlight the need to reframe, and foster more effective workplace relations, particularly between key stakeholders, in order to maximise the effectiveness of nurse educator contribution to practice, professional identity and an organisation.

7.5 Limitations of the Study

This research has generated a theoretical understanding that depicts the patterns of meaning that constitute the role of the public sector employed nurse educator and the contribution of this role in the context of the Queensland Health care system and thus the results are particularly pertinent to that context.

Observations of participants in work units for data generation in this study were not undertaken owing to practical constraints (e.g. time, finances, distance and access). Given the emphasis of symbolic interactionism (Bulmer, 1969; Stake, 1995) on observation of actions and interactions in the work setting, direct observation of study participants interacting with nurse educators in the work setting may have contributed further insight and additional data to the research.

Although no researcher is totally objective (Charmaz, 2006), the position of the researcher as an 'insider' (Nursing Director, Education) may be viewed as a limitation. Being an 'insider' could be construed as the researcher being too close to the data and thus imposing their pre-conceived ideas rather than undertaking a journey of exploration of experiences and deriving meanings regarding nurse

educator actions, interactions and contribution from the data. Notwithstanding, the researcher's professional and 'insider' knowledge was also a strength, as knowledge of the role informed critical explanation of literature and the study intent. Constant comparative analysis, reflection, and discussion with supervisors, were strategies used to reduce researcher bias.

7.6 Methodological Tensions

Tension arose in the latter stage of analysis between adherence to the grounded theory method and the desire to undertake analysis in a more unstructured manner. Grounded theory shaped both the analysis process and the structure of the research findings. This required data to be re-consulted multiple times in an effort to ensure that the analytical method was neither too concrete nor overly abstracted from the data and resulted in considerable researcher frustration.

The researcher initially attempted to construct a substantive theory rather than produce a theoretical understanding. A focus on the former resulted in an initial set of categories that oversimplified the complexities of the social context. Excessive amounts of time and effort were expended seeking to reduce very large amounts of data and diverse experiences into inter-related categories without diluting the complexities of the research situation. Data were analysed and compared to identify what it was believed that the participants were saying to the researcher. Interpretation not supported by the data was discarded. Data were scrutinised for similarities and differences between concepts. The researcher had to learn to trust her instincts and interpretation of what was seemingly important and let interaction with the data shape the direction of analysis. This process was not easy and at times was quite stressful and overwhelming. The researcher who was not used to taking the approach adapted to data interpretation. However, while participation in the analytical process was challenging, it assisted the researcher to obtain rich data, the analysis of which captured the complexity and variation of life as a hospital employed nurse educator. Although the research was at times weighed down by the nature of the analytical process, this experience does not appear to be unique since others, including Corbin and Strauss (2008), report similar views. The process has nonetheless produced findings that contribute to the understanding of the

role and contribution of the hospital employed nurse educator and add new significant knowledge that contributes to what is already known (Williams, 2010).

It is acknowledged that generalisation of the findings to other contexts may be limited if data are not comprehensive and interpretation is not broad enough (Strauss & Corbin (1990, p. 23). In this study it is acknowledged some of the theoretical explanations offered may be modified if exposed to constant comparison with new data.

The intent of this research was to gain greater appreciation of the participants' world and interactions within that world with particular regard to the role of the nurse educator and the contribution they make in the public sector (Janesick, 2000). When colleagues review the research and believe it to be relevant to their particular context, findings may be transferable. A decision on the degree of transferability is the responsibility of any individual considering the findings rather than the researcher of the original study (Barbour, 2005).

7.7 Lessons Learnt

There are numerous lessons gained from this study. The most salient lesson has been to allow sufficient time and patience when using grounded theory for the management and analysis of the volume of data associated with and produced from fifty-five interviews. The researcher needed to develop patience during data analysis and in the generation of theoretical understanding which was a humbling and sometimes frustrating experience, not appreciated during the earlier stages of data collection and analysis.

Obtaining ethics approval to commence this study proved to be challenging and resulted in six month protraction of the study period and duplication of effort. The employing agencies comprised eight health service districts and one university at the time of commencement and ethical approval was required from each participating facility. Unfortunately, given the nature, size and diversification of the statewide organisation, even though there is a centralised Human Research Ethics Committee, ethics approval in all health service districts required separate

submissions. Some ethics committees met only when a critical mass of submissions was received, while others were working through a backlog of submissions. Ethics approval requirements resulted in duplication and modification of submissions since some members of ethics committees were unfamiliar with grounded theory, and they required further written and verbal clarification. It was impossible to foresee all requirements since in most instances issues had been discussed with the chair of each committee or delegate prior, during and post approval process. The researcher has learnt for future ethics submissions to not rely only on published guidelines and timelines and to allow at least three times the stated time for submission approval. The researcher has also learnt that, irrespective of the quality of the ethics submission, there is considerable variance in the understanding of qualitative research in health care organisations.

The availability of extended, regular periods of leave to foster thinking and writing to obtain a consistent approach would have been beneficial. An approach of 'fitting in' research around an extensive full time management position with minimal periods of consistent time to research was a challenge. This experience caused frustration, extended timelines, and was not conducive to reflective thought.

Consistency of supervision and expertise of supervisors in the research methodology along with a positive rapport with supervisors are important. While an early change in primary supervisor did not have any adverse effect on overall support, it did have a slowing effect on completion. It was also unsettling and required reframing and the establishment of new study-supervisor relationships. This took additional time and effort for both researcher and supervisors.

7.8 Further Research

The findings of this study revealed the complexity of the hospital employed nurse educator role and the diversity of experiences, skills and contexts that define and redefine the role. While the theoretical understanding *negotiating boundaries* contributes new knowledge further research might focus on policy, managers' and key stakeholder support for nurse educators, the culture of learning within the workplace environment, the nature and effects of relationships and the influence of contextual conditions in differing work environments. Research focusing on

reducing role ambiguity would be advantageous in enhancing efficacy between nurse educator and other hospital employed clinical education support roles (e.g. Clinical Nurse Facilitator (RN/EN Support)).

Research focusing on attitudes, engagement patterns in CPD, understanding professional expectations, influences on clinical indicators and contribution to best practice is also seen as required. Given that since July, 2010, mandatory participation in CPD for health professionals in Australia has been implemented as a requirement to relating professional registration (AHPRA, 2010), research studies with the aforementioned intent will assist in evaluating health professionals' attitudes, satisfaction and compliance with respect to this requirement. It will also assist in determining changes and/or improvements in practice standards related to mandatory participation and its impact on professional and organisational outcomes. To date, and given the implementation of this requirement, research focusing on the effectiveness of the requirement has not been conducted in Australia. Further research will facilitate enhanced exploration of the hospital employed nurse educator's role and their contribution to assist colleagues in meeting AHPRA (2010) CPD expectations.

Research outcomes highlight issues regarding 'hidden' roles, visibility, engagement, relationships, power imbalances and perceptions of devaluing and bullying. As such there clearly is a place for research examining the 'politics of nurse education practice'. Political tension and inconsistent expectations currently have widespread organisational and industry ramifications for continued resourcing of the nurse educator role in an activity-funding model where the nurse educator contributes indirectly to patient outcomes and in a role that is positioned in a state of marginality given that clinical care needs take precedence in the workplace.

Further research could examine strategies to strengthen and sustain relationships between the nurse educator and key stakeholders, especially nurse unit managers and clinical nurse facilitators (RN/EN Support). Currently the nurse educator role is de-valued in certain circumstances and contexts, and further research to identify strategies to remove workplace horizontal violence is of high priority.

7.9 Recommendations

While findings and recommendations are directly relevant to the Queensland context, these should contribute to national and international debate surrounding both the role of the hospital employed nurse educator and systemic support for continuing professional development. Recommendations from this study are as follows:

- Achieve statewide agreement, policy and guidelines in relation to the role of the nurse educator.
- Explore and implement options to address contextual needs including nurse educator work unit engagement, visibility, profile and relationship building.
- Undertake action research to foster a team culture.
- Undertake research to explore and address bullying and horizontal violence associated with the role.
- Establish guidelines for educational requirements, training, induction, transition and upskilling for staff undertaking nursing education roles within Queensland Health.

The findings and recommendations of this study will be published in peer reviewed journals and presented at Queensland Health statewide Nursing Governance Committees. Presentations will be made to health service district/facility nurse leaders and at three international conferences. It is anticipated that study findings will provide impetus for further scholarly inquiry, research, policy development and education.

7.10 Conclusion

This research brings a better understanding of the role and the work context of participants. The theoretical understanding, *negotiating boundaries,* demonstrates the social processes whereby the nurse educator role is both shaped by and shapes the changing realities of clinical practice and the educational needs of nurses.

The research has emphasised processes that both influence and impede effective role application and contribution, including some not addressed in existing literature. It also identified further research and should contribute to the debate regarding the nurse educator role. This new knowledge about hospital employed nurse educators and their contribution to continuing development needs of the profession provides a useful structure to examine nurse educator support, and the mechanisms that are meant to foster constructive workplace learning environments, collaborative relationships and effective contributions to better health care. It highlights issues and factors influencing the nurse educator and provides a platform for further development regarding role, contribution, appreciation and engagement.

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Appendix 1



INFORMATION SHEET

Study Title: The role of the public sector hospital employed nurse educator in contributing to the continuing education needs of the nursing profession: A grounded theory study.

Principal Investigator: Robyn Fox (07) 36468546.
RobynL_Fox@health.qld.gov.au
Principal Supervisor: Dr Alan Barnard (07) 31383893 a.banard@qut.edu.au
Associate Supervisor: Dr Gary Day (07) 38645460 g.day@griffith.edu.au

Dear Colleague,

You are invited to participate in a research study being undertaken by Robyn Fox as a doctorate student of the School of Public Health, the Queensland University of Technology. Ethical approval for this study has been obtained from both Queensland Health and the Queensland University of Technology. Permission for you to be contacted so that an invitation to participate in this study can be extended to you has also been granted by Queensland Health.

The purpose of this research is to discover and explain the role of the hospital employed nurse educator in contributing to the continuing education needs of the nursing profession within the Australian context. This research is seen as valuable as there have been very few significant studies examining this classification of nurse or their contribution to the development of the nursing profession over the past twenty years. The study aims to develop knowledge that will inform policy and policy makers on issues related to the hospital employed nurse educator role.

You have been invited to participate in this study because you are believed to be a valuable source of information. If you agree to participate in the study, you will be invited to take part in an individual interview/discussion to gather information related to your perceptions of the issues. A snap shot demographic form will also be provided for completion to assist with data analysis. All personal information will be kept strictly confidential and any information extracted from the demographic form and the interview will be kept anonymous. If you are willing to participate in the study I will contact you to negotiate a time that is convenient to you and to identify a suitable venue.

If you agree to participate in the study, it is anticipated that the interview will take approximately I hour. The sessions will be audio-taped, with your permission. All information resulting from this study will anonymous and will not identify you in any way, thereby ensuring the confidentiality of your responses.

A summarised report of the outcomes of the study will be available to be mailed to you at completion of the study. If you have any questions, concerns or require further information regarding the study please contact me on phone (**07) 36468546** or by e-mail RobynL_Fox@health.qld.gov.au (work).

A Consent Form is attached to this information sheet. If you agree to participate in this research study please sign the Consent Form and return it to me using the pre-paid self-addressed envelope provided. It is also requested that you agree to be contacted again by the researcher if additional information is required or if there is a need for clarification of the information that has been collected. Your participation in this study is voluntary and you can withdraw at any stage without any adverse effects to you or the role in which you are employed.

If you do not agree to participate in the study, thank you for your consideration. If you would like to clarify any aspect regarding this study please contact or either of the supervisors listed above.

Yours sincerely,
Robyn Fox

"This study has been reviewed and approved by the Royal Brisbane & Women's Hospital Health Service District Human Research Ethics Committee. Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study or your rights as a participant, or should you wish to make an independent complaint, you can contact the Coordinator or Chairperson, Human Research Ethics Committee, Royal Brisbane Hospital, Herston, Qld, 4029 or telephone (07) 3646 5490".

or

The Research Ethics Officer QUT (07 2864 2340 ethicscontact@qut.edu.au should there be any concerns about the nature and/or conduct of the research study in relation to the student undertaking the research.

Appendix 2

STATEMENT OF CONSENT

Study Title: The role of the hospital employed nurse educator in contributing to the continuing education needs of the nursing profession: A grounded theory study

Principal Investigator: Robyn Fox (07) 36468546. RobynL_Fox@health.qld.gov.au

Principal Supervisor: Dr Alan Barnard (07) 31383893 a.banard@qut.edu.au

Associate Supervisor: Dr Gary Day (07) 38645460 g.day@griffith.edu.au

In signing this document I agree to participate in this research study. It also indicates that I have read the information sheet and have been informed about the nature and purpose of the research study and:

I understand that I may not directly benefit from this study.

I understand that the results of the study will be disseminated by conference presentation and/or publication. I also understand that a written summary of the study findings will be provided to participants who request it and may be provided to other stakeholders such as recruitment site ethics committees, healthcare and nursing organisations. I understand that all verbal, written and published information resulting from this study will not contain my name or identify me in any way, thereby ensuring the confidentiality of my responses.

I understand that my participation in this study is voluntary and I can withdraw from the study or refuse to answer any specific questions during interview at any stage without any adverse effects to myself or the role in which I am employed. I also understand the demographic information collected will be used purely to provide a basis to compare data and that this none of information will contain details of my identity.

I have also been informed that I may contact any of the investigators and identified above should I wish to clarify any aspect regarding this research study.

I agree to be contacted again by the researcher if additional information is required or if there is a need for clarification of the information that has been collected.

NAME (print):_____

SIGNATURE: _____

DATE: …. /…. /.....

TELEPHONE CONTACT: _____

Principal Investigator: SIGNATURE: _____

DATE: …. /…. /.....

"This study has been reviewed and approved by the Royal Brisbane & Women's Hospital Health Service District Human Research Ethics Committee. Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study or your rights as a participant, or should you wish to make an independent complaint, you can contact the Coordinator or Chairperson, Human Research Ethics Committee, Royal Brisbane Hospital, Herston, Qld, 4029 or telephone (07) 3636 5490".
or
The Research Ethics Officer QUT (07 2864 2340 ethicscontact@qut.edu.au should there be any concerns about the nature and/or conduct of the research study in relation to the student undertaking the research

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If you wish to receive a plain English version of the outcomes of the study please provide your name and address in the section below for mailing purposes.

_____
_____
_____
_____
_____
_____

Appendix 3

Queensland Government
Queensland Health

DEMOGRAPHIC INFORMATION

Study Title: The role of the hospital employed nurse educator in contributing to the continuing education needs of the nursing profession.

Could you please complete the following questionnaire by ticking the appropriate box or by providing a response for the requested information?

1. **Age:**	20 to < 30 years 30 to < 40 yrs 40 to < 50 yrs 50 to < 60 yrs ≥ 60 years	☐ ☐ ☐ ☐ ☐	**7. How many years have you worked in Queensland Health**	<1 year < 1 to <2 yrs 2 to < 5 yrs 5 to < 10 yrs 10 to < 15 yrs 15 to < 20 yrs ≥ 20 yrs	☐ ☐ ☐ ☐ ☐ ☐
2. Gender	Male Female	☐ ☐	**8. How many years have you worked in the facility in which you are employed**	<1 year < 1 to <2 yrs 2 to < 5 yrs 5 to < 10 yrs 10 to < 15 yrs 15 to < 20 yrs ≥ 20 yrs	☐ ☐ ☐ ☐ ☐ ☐
3. Classification/ Role **4. Position held (Please specify & include specialty area of practice if relevant)**	DDON DON ND NUM NE Other _____ _____ _____ _____	☐ ☐ ☐ ☐ ☐ ☐	**9. Are you currently studying towards further qualifications?**	No Yes	☐ ☐
5. Location HSD	Metropolitan Provincial Rural	☐ ☐ ☐	**10. Please list the qualification/s being completed (if relevant)** _____ _____ _____ _____		
6. How many years' experience do you have in your current role	< 1 year < 1 to <2 yrs 2 to < 5 yrs 5 to < 10 yrs 10 to < 15 yrs 15 to < 20 yrs ≥ 20 yrs	☐ ☐ ☐ ☐ ☐ ☐ ☐	**11. Please document any qualifications that you have completed** _____ _____ _____ _____		

Appendix 4

OVERALL STUDY GROUP DEMOGRAPHICS

Group	Number	Percentage	Gender		Location		
			M	F	Metro	Prov	Rural
Line Managers (Nursing Directors, DONs, DDON's)	13	24%		13	6	3	4
NUM'S	11	20%	1	10	8	2	1
Nurse Educators	21	38%	1	20	8	8	5
Clinical Nurses	10	18%		10	7	1	2
Sub Group Totals			***2***	***53***	***29***	***14***	***12***
Participant Total	**55**						

Legend

LM = Line Managers
DDON = District Directors of Nursing
DON = Directors of Nursing
NUM = Nurse Unit Managers
NE = Nurse Educator
CN = Clinical Nurse

Gen = Gender
F = Female
M = Male
Metro = Metropolitan
Prov = Provincial

Table 1 Demographics of Line Manager Study Group

	Q1: Age					Q2: Gen		Q3: Role					Q5: Location			
	20 - 30	31 - 40	41 - 50	51 - 60	> 60	M	F	DDON	DON	ND	NUM	NE	Other	Met	Prov	Rural
LINE MAN	0	0	6	6	1	0	13	3	2	8	0	0	0	6	4	3

Table 2 Demographics of Nurse Educator Study Group

	Q1: Age					Q2: Gen		Q3: Role					Q5: Location			
	20 - 30	31 - 40	41 - 50	51 - 60	> 60	M	F	DDON	DON	ND	NUM	NE	Other	Met	Prov	Rural
NURSE ED	1	3	12	3	2	2	19	0	0	0	0	21	0	8	8	5

Table 3 Demographics of Nurse Unit Manager Study Group

	Q1: Age					Q2: Gen		Q3: Role					Q5: Location			
	20 - 30	31 - 40	41 - 50	51 - 60	> 60	M	F	DDON	DON	ND	NUM	NE	Other	Met	Prov	Rural
NURSE UNIT MAN	1	2	5	3	0	1	10	0	0	0	11	0	0	7	3	1

Table 4 Demographics of Clinical Nurse Study Group

	Q1: Age					Q2: Gen		Q3: Role					Q5: Location			
	20 - 30	31 - 40	41 - 50	51 - 60	> 60	M	F	DDON/DON	ND	NUM	NE	CN	Other	Met	Prov	Rural
CLIN NURSE	2	1	5	2	0	0	10	0	0	0	0	9	0	7	2	1

Table 5 Post Graduate Awards

	Number Participants	Graduate Certificate	Graduate Diploma	Masters	PHD / Doctorate
*Line Manager	13	15	11	9	1
*Nurse Educators	21	17	5	7	
*NUM's	11	7	6	1	
CN's	10	8	2		

*Collectively a number of Line Mangers Nurse Unit Mangers and Nurse Educators participating the study have attained more than 1 post graduate award
5 Nurse Educators identified they possessed an education award

Appendix 5

OVERVIEW OF RESEARCH DESIGN AND RELATIONSHIP TO PROVISIONAL QUESTIONS

Research Questions	**Data Gathering Strategy**	**Sources of Data & *Analysis***	**Timeline**
Relevant background from documents and literature	• Documentation analysis Undertaken x 2 • Provisional literature review • Revised literature review ongoing post commencement of analysis • Literature review update during thesis development (undertaken periodically)	Analysis of literature and documentation from: • QH and Government documents / policies / minutes / reports/ reviews • Available Literature • Available Literature • Available Literature • Available Literature	July 2007 – November 2007 Re-review of available documentation – December 2011 – March 2012 January 2007 – March 2007 Revised December 2007 – January 2008 February 2009 – June 2009 January 2010 – November 2012 February 2013 – March 2013
1. Tell me about a typical day of a nurse educator? 2. What do you believe is the appreciation that the majority of nursing staff	• Demographic Survey • In-depth semi-structured interviews	• Consideration of the Health service District context and demographic content required • Preparation of interview guidelines • Questions / concepts informed by literature, and documentation review	March – September 2008 December 2007 – March 2008

Research Questions	Data Gathering Strategy	Sources of Data & *Analysis*	Timeline
would have regarding the elements of a nurse educator role? 3. What do you believe the evolving nature of the role should be? 4. What do you believe is the nature of the hospital employed nurse educator contribution to the continuing education needs of the nursing profession? 5. What processes are used to facilitate nurse educator contribution to continuing education and clinical practice?	• Ongoing literature review • Other data gathering methods will be employed as and when the need is determined • Re - review of data	• Semi-structured interview plan developed by reviewing information from previous data gathering strategies →i.e. emerging and confirming themes, discontinued themes • Interview questions will be modified as a result of information taken from previous data gathering strategies →i.e. emerging and confirming concepts, discontinued concepts • Ongoing process of exploration inspection, interpretation and review *Constant Comparative Method, coding of data* • Continuation of data analysis; Reconsideration of theoretical understandings • Presentation of concepts and categories • Data re- reviewed in respect to theoretical understandings and categories. Re-reviewed in respect to theoretical understandings and constructed meanings.	March – September 2008 March – September 2008 May 2008 & April 2009 February 2009 – June 2009 January 2010 – August 2012 November 2008 – June 2009 October 2012 March 2012 – December 2012 October 2011 – February 2012 October 2012 – December 2012 February 2013 – March 2013

Appendix 6

ADVANTAGES AND LIMITATIONS OF DATA COLLECTION METHODS

Advantages	Limitations	Strategies to address limitations
Documentation		
Readily accessible, non-intrusive to the research Stable – can be reviewed repeatedly Provides a checking system for information found in survey and interviews (Yin, 2003) Assists in review why resource allocation decision making and policy development may have occurred	Not produced specifically for research, therefore may contain much irrelevant data. Reduces potential bias of author (Backman & Kyngas, 1999; Yin 2003)	Use as a component of multi-faceted data collection methods – findings are cross referenced and confirmed if possible Documents developments developed for similar purposes (e.g. Job descriptions) used benchmarked
Survey – demographic		
Enables collection of standard information from a large numbers of participants (Patton, 1990)	Response rate commonly low Structured nature does not allow for exploration of emerging and unanticipated issues	Maximize return rate – requested return from participants prior to or immediately after the face to face interview. Similar requests for telephone interviews Utilize at time of interviews Obtain consent to follow up participants if clarification is required.

Advantages	Limitations	Strategies to address limitations
In depth semi-structured interviews		
Held in natural setting as opposed to experimental situations (Backman & Kyngas, 1999; Yin 2003)	May need to put participant at ease Suitable environment, access, constraints, interruptions and confidentiality Expensive Requires trained interviewers Possible interviewer bias Limits sample size Time consuming	Reduce interviewer bias – discuss own world view with supervisors. Use a relaxed non-confrontational approach and allow adequate time to put participant at ease to gain in-depth appreciation of their understandings Interview in a quite private environment out of the participant work unit Cross check prior environment at commencement of telephone interview. Reschedule if unable to secure access to conducive environment. Continue interviewing until no new information is gained.
Additional topics may emerge during interview (Krueger, 1994)	May digress from research aim and or limit the scope and amount of information collected	Undertake a follow up interview where relevant May require modification to research questions Increase sample size until no new data Continue to interview until no new information is generated.
Flexibility to explore unanticipated issues not possible in more structured questioning such as survey (Krueger, 1994).	Difficulty of analysis and interpretation of results	Maintenance of focus on research questions and purpose. Modify research question in theme emerging Use coding software to assist with management of analysis

Advantages	Limitations	Strategies to address limitations
Allows the interviewer to be highly responsive to individual differences (Patton, 1990; Polit & Beck, 2008; Yin, 2003)	Possibility of bias, poor recall or inaccurate articulation (Patton, 1990; Polit & Beck, 2008) may not capture aim of the research	Consider interview data with information from other sources e.g. documents produced. Peer checks, external review Re frame within focus of study consider participant world views. Discussions with supervisors regarding the data and participant views.
'High face validity' (Barbour, 2005)	Research bias Poor recall or inaccurate translation	Encourage participants to fully contribute during interview and provide expanded responses & free comment. Confirm by summary consensus of discussion points. Confirm response confidentiality. Data sets direction not researcher views

Appendix 7

PROVISIONAL CODES

The provisional analysis resulted in the emergence of 62 codes

1. Workloads
2. Stress
3. Professional isolation
4. Political, bureaucratic & organisational impacts
5. Burnout
6. Technology
7. Changes in expectations
8. Shift work versus service provision
9. Large numbers of inexperienced staff
10. High throughput and acuity
11. Variations in stakeholder expectations
12. Competing work demands
13. Nurse educator involvement
14. Knowledge and Skill Sets
15. Educator background
16. Experience
17. Flexibility
18. Role competence
19. Uniqueness of Nurse Educator role
20. Practice Support
21. Change Agent
22. Credibility
23. Leadership
24. Autonomy
25. Direct and Indirect Support
26. Undervalued
27. Multifaceted and complex
28. Frustrating
29. Challenging
30. Ambivalence about nurse educator contribution
31. Support
32. Conduit
33. Bullying (by colleagues and other Nurse Educators)
36. Responsibility
37. Clinical demands vs. education
38. Culture of Learning / Knowledge Worker
39. Personalities
40. Reduce feelings of fear of unknown and isolation
41. Reduction in clinical and other related incidents (Work Place Health and Safety)
42. Shift work impacts
43. Communication
44. Teamwork
45. Trust
46. Dependability
47. Collaboration
48. Work Ethic
49. Networks
50. Work Ethic
51. Attrition, retention and recruitment
52. Engagement
53. Visibility
54. Consultancy
55. Providing knowledge
56. Self-awareness
57. Reduce clinical incidences
58. Integral role
59. Hidden role
60. Specialty area of practice
61. Competing key stakeholder demands
62. Issue resolver

Appendix 8

INTERIM CATEGORIES AND CODES

Provisional Categories	Codes
Relationship Interaction	▪ Engagement ▪ Visibility Networks & partnerships ▪ Degree & nature of support ▪ Communication/maintaining interactions ▪ Teamwork & team processes ▪ Trust/expectations ▪ Collaboration
Expectations of Role	▪ Ongoing capacity building ▪ Clinical & demand indicator application ▪ Mandatory skills/Competence/Assessments/Remediation ▪ Contribute to retention & recruitment & reduced attrition ▪ Enhance reputation of nursing services/facility ▪ Resource Person/Change Agent ▪ Support peers, practice changes, standards & evidence application ▪ Effective interaction in clinical service activities
Role Characteristics	▪ Unique multifaceted & complex ▪ Frustrating & challenging ▪ Change Agent/Leader) ▪ Initiative & Autonomy ▪ Support & consult ▪ Conduit between theory and practice ▪ Responsibility/Work Ethic
Role Blurring	▪ Personalities – variation/strong divergence ▪ Appreciation of the role of others ▪ Impartial ▪ Used as filler' when work units busy ▪ Responsibilities
Lack of regard for Nurse Educators	▪ Bullying & lack of engagement ▪ Ambivalence/lack of engagement ▪ Peripheral to work unit ▪ Education services & initiatives devalued ▪ Responsibility for education

Provisional Categories	Codes
Knowledge & Experience	▪ Education knowledge vs. clinical knowledge and needs ▪ Application - Flexible/multifaceted ▪ Specialty area of practice – focus education ▪ Need post graduate awards ▪ Not 'expert' in all things/background ▪ Need to standardise core elements - Competency Standards/Job Descriptions
Contribution	▪ Link between theory and practice ▪ Conduit between professional and clinical ▪ Help staff not to be frightened of different or unusual practice ▪ Self-manage ▪ Resolves issues ▪ Oversee/Coordinate education initiatives ▪ Standards ▪ Resource/support person/being there
Work Demands	▪ Workloads; shift work vs. service provision; inexperienced staff, large numbers, high turnover ▪ Stress & Burnout ▪ Professional isolation ▪ Political, Bureaucratic, Organisational ▪ Changes – work, staffing, roles, technology ▪ High throughput, high acuity ▪ Variations between stakeholder expectations
Learning Environment	▪ Maintain standards of practice ▪ Culture of Learning/Knowledge Worker ▪ Input from others confirmation of ideas ▪ Progression & support for learning/education initiatives/Constant state of tension - clinical demands verse education ▪ Tension between competing demands & stakeholder groups ▪ Response to participation of others
Accountability/ Responsibility	▪ Credibility ▪ Minimum standard ▪ Flexibility

Appendix 9

PROVISIONAL FIVE (5) MAJOR CATEGORIES AND SUB-CATEGORIES CONCEPTS

Categories	Sub Categories
Attributes and Expectations	▪ Characteristics o Multifaceted complex o Hidden aspects o Consultancy/Support ▪ Teaching o Facilitate learning o Reflection on interaction o Structure learning ▪ Expectations o Integral resource o Educational Leadership o Safety Net' for practice standards/Theory/practice conduit o Effective Clinical Service Support o Accountably & Credibility
Foster Leaning Environment /culture/ practice ▪ Facilitating a culture of learning	▪ Nurse educator contribution o Education & knowledge o Engagement o Flexible/Application o Expertise o Variability in support and application ▪ Generate Tension in System ▪ Support Standards ▪ Support Capacity Building ▪ Projection of Self ▪ Promotion of group cohesion o Share knowledge o Reach out o Confirm ideas direction
Shaping Relationships	▪ Social presence o Engagement & o Visibility ▪ Networks/Partnerships ▪ Services Devalued ▪ Interaction (Responsibility/Trust) ▪ Lack of Regard o Bullying

Categories	Sub Categories
	o Appreciation o Inequity
Work Demands	▪ Stakeholder expectations & variations ▪ Work & Workloads ▪ Support Processes ▪ Professional & Organisational Considerations o Isolation o Stress & Burnout ▪ Competing Priorities ▪ Ongoing Change
Contributions	▪ Link between theory and practice ▪ Conduit between professional and clinical ▪ Help staff not to be frightened of different or unusual practice ▪ Self-manage ▪ Resolves issues ▪ Oversee/Coordinate education initiatives ▪ Standards ▪ Resource/support person/being there ▪ Clinical organisational and professional ▪ Codes/Policies ▪ Research ▪ Evidence based practice ▪ Conferences ▪ Continuing professional development/upskilling

Appendix 10

FINAL TWO (2) MAJOR CATEGORIES AND SUBCATEGORIES

Categories	Sub Categories
Reflecting on Attributes and Expectations	▪ Characterising the Nurse Educator ▪ Managing Expectations
Constructing Workplace Leaning	▪ Fostering Learning o Visibility and Engagement o Tension in the System o Valuing o Work Difficulties

Appendix 11

MEMO SAMPLE

Power and de-de valuing

Most of the clinical nurse group participants were reluctant to discuss the relationship between the nurse unit manager and nurse educator more so than then relationship between them and the nurse educator. They tended to baulk at this speaking about the concept of relationships in the work unit and worded their responses very careful to avoid any potential that they were criticising nurse unit managers. Perhaps this is due to their line management relationship with the nurse unit manager as opposed to the collegial or support relationship with the nurse educator. The concepts of power and impacts on professional achievements and the type of shifts allocated were identified by a few as concerns if they 'sided with the nurse educator'. This reluctance could impact on perceptions and expectations of the nurse educator especially if there is confusion between the role of the Clinical Nurse facilitator and the nurse educator in a work unit as confusion between the roles was a reason why some of clinical nurses didn't identify the nurse educator as an integral member of the work unit team but an indirect contributor. However all reiterated the nurse educator role was needed and that most believed that the relationship between the nurse unit manager and nurse educator should be better or collaborative or more engagement. Those interviewed to date all used similar language in identifying the nurse unit manger relationship was more critical to them than a relationship with the nurse educator.

Because of these different realities it may be that it is too hard for the CNs to have a clear perspective about the process as they receive different information from different groups. Thus the meanings expressed by this group differ from others. Is this because they are in less powerful situation as well? They may feel the pain but tend to compete for professional space. How do their meanings contribute to issues and influence shared meanings? (Memo 25/10/09 related to CN reluctance to speak about work unit concerns about relationships and possible implications).

Appendix 12

ETHICS APPROVAL

University Human Research Ethics Committee

HUMAN ETHICS APPROVAL CERTIFICATE

NHMRC Registered Committee Number EC00171

Date of Issue:26/7/11 (supersedes all previously issued certificates)

Dear Mrs Robyn Fox

A UHREC should clearly communicate its decisions about a research proposal to the researcher and the final decision to approve or reject a proposal should be communicated to the researcher in writing. This Approval Certificate serves as your written notice that the proposal has met the requirements of the *National Statement on Research involving Human Participation* and has been approved on that basis. You are therefore authorised to commence activities as outlined in your proposal application, subject to any specific and standard conditions detailed in this document.

Within this Approval Certificate are:

* Project Details
* Participant Details
* Conditions of Approval (Specific and Standard)

Researchers should report to the UHREC, via the Research Ethics Coordinator, events that might affect continued ethical acceptability of the project, including, but not limited to:

(a) serious or unexpected adverse effects on participants; and
(b) proposed significant changes in the conduct, the participant profile or the risks of the proposed research.

Further information regarding your ongoing obligations regarding human based research can be found via the Research Ethics website http://www.research.qut.edu.au/ethics/ or by contacting the Research Ethics Coordinator on 07 3138 2091 or ethicscontact@qut.edu.au

If any details within this Approval Certificate are incorrect please advise the Research Ethics Unit within 10 days of receipt of this certificate.

Project Details

Category of Approval:	Human non-HREC		
Approved From:	19/11/2007	**Approved Until:**	19/11/2010 (subject to annual reports)
Approval Number:	0700000760		
Project Title:	The role of the hospital employed nurse educator in contributing to the continuing education needs of the nursing profession		
Experiment Summary:	This study will fill in some gaps in knowledge, minimise apparent confusion regarding the contemporary role of the hospital employed nurse educator plus stimulate further exploration and interventions pertaining to the classification of registered nurse.		

Investigator Details

Chief Investigator: Mrs Robyn Fox

Other Staff/Students:

Investigator Name	Type	Role
Dr Alan Barnard	Internal	Supervisor
Dr Charrlotte Seib	Internal	Supervisor

Participant Details

Participants:
Queensland Health Nursing staff = 120 nurse educators, 20+ line managers, 300 nurse unit managers

Location/s of the Work:
QUT and Queensland Health

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- Attachment I is a letter listing some matters specified by the National Health and Medical Research Council to which you as the research worker must adhere.

- Attachment II gives the Committee composition with specialty and affiliation with the Royal Brisbane & Women's Hospital.

- You are required to provide a report on any pilot study and the outcome of the study at the completion of the trial or **annually** if the trial continues for more than 12 months.

- If any subsequent change/amendment is made to the protocol it will be necessary for you to obtain approval from the Human Research Ethics Committee. In addition a summary of the amendments and a comment is required from the Principal Investigator. All amended documents must contain revised version numbers, version dates and page numbers. Changes must be highlighted using Microsoft Word "Track Changes" or similar. Please contact the HREC Coordinator if assistance is required.

- Serious Adverse Events must be notified to the Committee as soon as possible. In addition the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form.

- If the results of your protocol are to be published, an appropriate acknowledgment of the Hospital should be contained in the article. Copies of all publications resulting from the study should be submitted to the Human Research Ethics Committee.

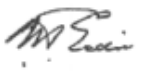
- Please ensure that a copy of any publication that results from this protocol is also forwarded to the Herston Medical Library for future reference.

- The Hospital administration and the Human Research Ethics Committee may inquire into the conduct of any research or purported research, whether approved or not and regardless of the source of funding, being conducted on hospital premises or claiming any association with the Hospital; or which the Committee has approved if conducted outside the Royal Brisbane & Women's Hospital Health Service District. This may include consultation with the Principal Investigator and/or a visit to the research site by a member of the HREC and/or Coordinator of the HREC.

Should you have any problems, please liaise directly with the Chairperson – RB&WH, Human Research Ethics Committee early in your program.

We wish you every success in undertaking this research.

Yours sincerely



Professor M J Eadie
Chair, Queensland Health Research Ethics Committee
29/10/2007

Appendix 13

STUDY APPROVAL - HEALTH SERVICE DISTRICT

Queensland Government

Queensland Health

Enquiries to: Lyndell Leitch, Manager Workforce Unit
Telephone: 3131 6982
Facsimile: 3131 6945
File Ref: CA00780

Ms R Fox
Nursing Director, Educator
Centre for Clinical Nursing
Royal Brisbane & Women's Hospital
Butterfield Street
HERSTON QLD 4006

Dear Ms Fox

Subject: Support for research study – The role of the hospital employed nurse educator in contributing to the continuing education needs of the nursing profession.

I am writing to confirm my support, pending ethical approval, for the above qualitative grounded theory research study. Access to ongoing education and training for health professionals is vital not only for the purpose of ensuring our workforce have the knowledge and skills to deliver safe, high quality health services but also as a key recruitment and retention strategy. Research findings from this study may help inform decision-making around future nursing education initiatives and the role of hospital employed nurse educators in developing our nursing workforce.

I look forward to reading the findings from this study.

Yours sincerely

Terry Mehan
General Manager
Central Area Health Service
17 / 10 / 2007

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Appendix 14

DATA GATHERING & ETHICAL CONSIDERATIONS

Data Gathering Strategy	Ethical Strategies
Documentation	Public records open to scrutiny. Provides cross check and credibility. May be in aggregated form.
Survey (Demographic)	A letter of introduction and explanation informed participants Response return confirmed agreement. The survey did not contain identifying information. Information collected assisted with analysis.
In-depth interviews	Consent of the interviewee to proceed with the interview and clarify issues of confidentiality was sought. Additionally considerations include: • information and Consent Forms are written clearly and concise • expectations clearly explained • opportunity for all participants to review and modify transcripts as relevant post interview • ensure individuals are not professionally compromised by non-participation o acceptable to withdraw at any stage without compromise to self o Researcher reinforces research role *Participant coding*: The letter allocated to participants involved in in-depth interviews was IDI. Additionally each group of participants needed to be allocated a code. The Codes use for participant groups was Line Manager – LM; Nurse Educator – NE; Nurse Unit Manager – NUM and Clinical Nurse – CN. Therefore in-depth interview example of LM IDI 1 (2) the LM denoted the group the 1 denotes the participant and the (2) the gender code. These codes align to the original participant.

Polit & Berg (2008); Glesne (2006)